DOCUMENT RESUME

ED 025 636 VT 007 381

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Home Health Aide Pilot Training Project. Final Evaluation Report.

Alameda County Health Dept., Oakland, Calif.; Office of Economic Opportunity, Washington, D.C. Community Action Program.

Pub Date Feb 68

Grant- Grant CG-8367 A

Note- 128p.

EDRS Price MF-$0.75 HC-$6.50

Descriptors- Achievement Tests, *Community Health Services, Companions (Occupation), Cost Effectiveness, Counseling, *Economically Disadvantaged, Educational Programs, *Health Occupations Education, Middle Aged, *Nurses Aides, Participant Characteristics, *Pilot Projects, Program Development, Program Evaluation, Recruitment

Identifiers- Alameda County Health Department, California, *Home Health Aide Pilot Training Project

Through the use of group interviews in which individuals were stimulated to interact on key questions, 100 applicants over the age of 45 and with incomes below the poverty standard were selected for training in two different 11-week training sessions. There were no requirements of education or experience. The first phase of the program was in a classroom-demonstration-discussion setting, the second phase in nursing homes, and the final phase in patients' homes. A basic education program was integrated with the vocational training. Eighty-three trainees successfully completed the course. of the 17 who did not finish, only two with reading levels of 3.7 and 4.6 respectively were terminated for lack of scholastic ability and were placed into basic education programs full- time in preparation for entry into a future home health aide class. A performance evaluation of 24 members of the first class who were employed immediately after graduation, indicated all were performing at a satisfactory level or above. Some recommendations are included. Economic costs and benefits are analyzed in the report and among attachments are a job description, a sample lesson plan, reports of group counseling meetings, a final course quiz, and a sample single lesson quiz, a performance checklist form, and a performance evaluation form. (JK)

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HOME HEALTH AIDE PILOT TRAINING PROJECT
FINAL EVALUATION REPORT

ALAMEDA COUNTY HEALTH DEPARTMENT
499 - 5th STREET
OAKLAND, CALIFORNIA 94607

1967

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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This project was granted USOEO number CG-8367A 12-30-66.

HOME HEALTH AIDE PILOT TRAINING PROJECT
FINAL EVALUATION REPORT
February, 1968

ALAMEDA COUNTY HEALTH DEPARTMENT
Oakland, California

Wilbur Hoff, Dr. P.H.; Project Director
Philomena Stewart, P.H.N.; Chief Public Health Nurse

INTRODUCTION

"This course have ment a great deal to me, because it have provided a way and a means for me to be able to give greater aide and service to the community in which I live. And it has made it possible for me to obtain a job as long as I am able so that I may become self-supporting and maintain a lively hood in the world that I live."

Thus commented a 47-year-old Negro woman who had just graduated from the first home health aide training class in the project. Formerly with little hope and few opportunities to look forward to in life she was barely supporting her 15-year-old daughter with welfare funds. Recruited from a poverty area she was one of 83 older poor adults who were trained and certified as home health aides. Her comments, written on the last day of class, sum up the feelings of many of the poor and the disadvantaged whom we were able to train for meaningful health jobs.

The Home Health Aide Pilot Training Project of Alameda County Health Department was aimed at attacking two critical problems which exist throughout the country -- inadequate health care and poverty. Both of these problems exist among our urban and rural populations. Within the county's jurisdiction live more than one million people, of whom an estimated 83,000 are persons 65 years of age or over and who are eligible for home health services. With the advent of the federal "Medicare" bill in 1966, the services of home health care became available to these aged persons.

One of the key persons who provides home care is the home health aide. Working under the supervision of the public health or registered nurse, the home health aide provides certain basic and important personal health services to the sick and disabled. The degree to which home care patients recover or become rehabilitated to their maximum potential depends to a large extent upon the effectiveness of the home health aide.

The Alameda County Health Department is responsible for the community health of its residents as well as for providing home health care to many of the aged who need it. The City of Oakland, fifth largest city in the state, is beset with serious social problems and has an unemployment rate of more than twice the national average. In view of the need for home care services within the county and the need for poor people to become employed, the Health Department believed it was urgent that persons be trained and employed to meet these needs. The Department therefore applied for and was granted funds by the Office of Economic Opportunity to conduct a one-year demonstration project. The project was sponsored at the federal level by the Community Action Program of the Federal Office of Economic Opportunity and the Division of Medical Care Administration of the U.S. Public Health Service. The project's two main aims were to train and employ older poor people for meaningful health careers and to provide more comprehensive health care to sick people in their homes by recruiting and training auxiliary health manpower.

Plan of the Report

This report is the final evaluation of the project. It contains results in the form of documented experiences gained during all stages of the project and evaluative data on the outcome of the training project. The ideas and recommendations presented herein are a compilation of some 20 staff members who contributed immeasurably to the project's success. This report is written in terms of the major phases and component parts of the project. For each phase, the events that took place and the results that occurred are described. Significant issues and experiences are discussed including both positive and negative outcomes. The intent has been to make this part of the report as objective as possible.

At the end of the report is a section on recommendations for future programs. This part lists suggestions which the staff feel should be considered and incorporated into future training programs of this kind. These recommendations are based both upon the objective data of the project and the collective experiences and points of view of the staff members.

The component parts of the report are as follows:

Purpose and Objectives of the Project
Recruitment of Trainees
Selection Process
Development of the Training Program
Individual Problems of Students
Results of Training
Special Training and Use of Health Aides
Employment of Home Health Aides
Administrative Issues
Economic Costs and Benefits
Recommendations for Future Programs
Summary

PURPOSE AND OBJECTIVES OF THE PROJECT

Due to the rapid increase of home care services for the chronically ill and aged, there arises a great need to employ supportive personnel to provide this care. The main purpose of the project was to demonstrate that older poor adults can be successfully trained as home health aides and that possibilities exist for their advancement in health careers.

The specific objectives were:

1. To increase the ability of Alameda County to meet the demand for home health care services.
2. To test the idea that older poor men and women, 45 years of age and over, can be recruited, selected and trained for successful employment as home health aides.
3. To test the success of different experimental approaches to recruitment, selection, training and employment of the older poor as home health aides, and other kinds of health aides with the possibility of career advancement in health careers.

To achieve these objectives, a grant of approximately $368,000 was awarded the health department to conduct a one-year demonstration project. The project period was initially from January 1 to December 31, 1967. (At the expiration date permission was obtained to extend the project several more months to utilize unused funds.) The grant covered the expenses of the project including the cost for some 20 administrative, clerical, recruitment and training staff and stipend money for 120 home health aide students.

The project plan is shown in Attachment I. This plan indicates the major phases of activities undertaken with target dates for their completion.

SUMMARY

The significant outcomes of the one year Home Health Aide Pilot Training Project conducted by the Alameda County Health Department are listed as follows:

1. Eighty-three persons over the age of 45 and with incomes below the poverty standard were recruited, trained and certified as Home Health Aides.
2. A number of other health aides were trained for home care and to work in other health program areas.
3. An 11-week training program was designed to develop specific knowledges, attitudes and skills required for home health care.
4. A performance evaluation was conducted on a selected group of 24 home health aides after 15 weeks on the job and results indicated that all were performing at satisfactory levels or above.
5. A basic education program was integrated with the technical training and the overall results showed that the average increase in mathematics ability due to 55 hours of instruction was 1.6 grade levels per student.
6. Different methods of recruitment, selection and training were tried and their results are discussed.
7. A training manual for home health aide students was developed along with an instructor's guide for using the manual.
8. The average cost of training and certifying each home health aide was $1,707. The economic benefits of the program are identified and discussed.
9. A large reservoir of potential manpower for the health services professions exists in the Oakland and Alameda County areas. Persons from this reservoir group who were recruited into the project demonstrated a great willingness to learn and a high level of interest and motivation to work in health programs.
10. The chief factor which prevented the training of additional home health aides in the project was the lack of jobs in the community.
11. Details of these and other results are discussed in the report.

RECRUITMENT OF TRAINEES

Recruitment activities began immediately after the project opened. A staff recruiter (Public Health Representative) was employed to work full time in recruitment activities. He had 15 years previous experience in the health department, was active in community affairs and knew the community target areas well. To assist him, two health aides were employed half-time. These aides lived in the target areas and also had previous experience working in the community under the health department.

1. Recruitment Criteria

The criteria used in recruiting applicants were those spelled out by the project grant and were as follows:

Age:	45 and over
Sex:	Male or female
Income:	Annual family income not to exceed the poverty standard (i.e., $4,000 for a family up to four members, more for additional dependents, etc.)
Education:	No requirement
Experience:	No requirement

2. Target Areas and Methods Used

Recruitment efforts were aimed primarily at the poverty target areas in the metropolitan Oakland area. Although most of the applicants came from these areas information about the project was conveyed to communities throughout the entire county in an effort to reach all persons who were eligible.

The recruiting team began to contact appropriate agencies and centers in the community to announce the purpose of the project and to recruit applicants. The following is a partial list of the places visited:

Four Oakland Neighborhood Service Centers (Poverty Target Area Centers)
State Department of Employment
Oakland Economic Development Council
Central Labor Council
Skills Center
Oakland Housing Authority - West Oakland Center
Hayward Poverty Center
Interdenominational Ministerial Alliance
Baptist Minister's Union
Various individual churches

Visits were made to these agencies at different times, depending upon the purpose and need of the organization. Some were contacted only once while to others, visits were made several times per week. Detailed information about the qualifications and functions of home health aides was supplied.

Male applicants were difficult to find. After several weeks of recruiting it became obvious to the staff that different ways must be found to obtain men. Efforts were concentrated on reaching men through male-type organizations and recreation clubs. Advertisements were run in the "Help Wanted" columns of the large metropolitan newspaper as well as in several local minority oriented news weeklies.

Announcements were also carried over several of the local radio stations. We made a special plea that men were needed to work in health careers, that education and experience were not required and that they would be given additional training in areas such as sanitation, dental health and immunization. It was hoped that our information would reach and attract more men than our previous efforts had.

Unfortunately, these recruiting efforts had very little effect. Five men did apply as a result of the radio and newspaper advertisements but they were rejected later because they had an income above the poverty standard.

3. Results

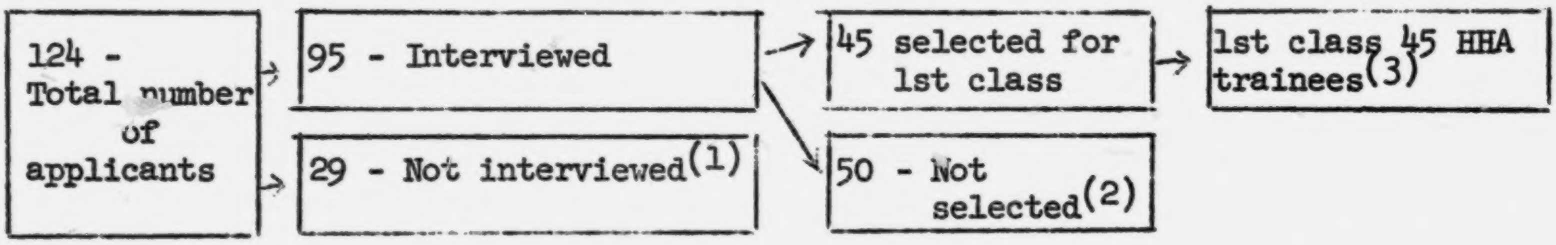
The results of the recruitment efforts can be described in terms of three training periods. Three training classes were programmed to occur one after the other with the beginning dates on April 3, June 26 and September 18. The three recruitment periods took place before these three beginning class dates and each occupied several months of time. The first recruitment period was from January 1 to April 3, the second from April 4 to June 10 and the third from June 11 to September 11.

It should be pointed out that at the beginning of the project the health department had approximately 150 health aide applications on file. These resulted from previous recruitment efforts of other poverty health programs in which health aides had been employed. A large portion of these applicants were under age 45 and did not meet the age requirement; however, most of these applicants were still interested in employment and some met the criteria for the home health aide project.

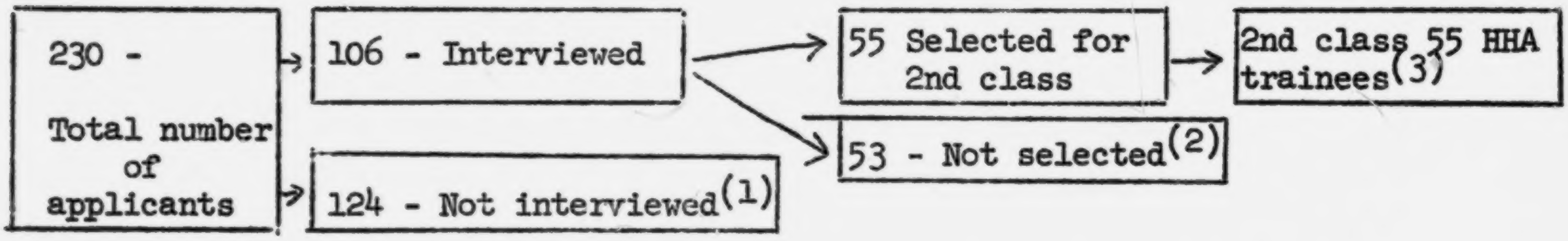
The results of the project's recruitment activities can be summarized in Diagram 1.

DIAGRAM 1

First Recruitment Period
January 1 - April 3, 1967


124 - Total number of applicants
95 - Interviewed
29 - Not interviewed(1)
45 selected for 1st class
50 - Not selected(2)
1st class 45 HHA trainees(3)

Second Recruitment Period
April 4 - June 10, 1967


230 - Total number of applicants
106 - Interviewed
124 - Not interviewed(1)
55 Selected for 2nd class
53 - Not selected(2)
2nd class 55 HHA trainees(3)

(1) Those not interviewed were screened out because they did not meet the criteria of age or income, they were no longer available, etc.

(2) Those not selected did not meet the selection criteria as described in section on "Selection Process".

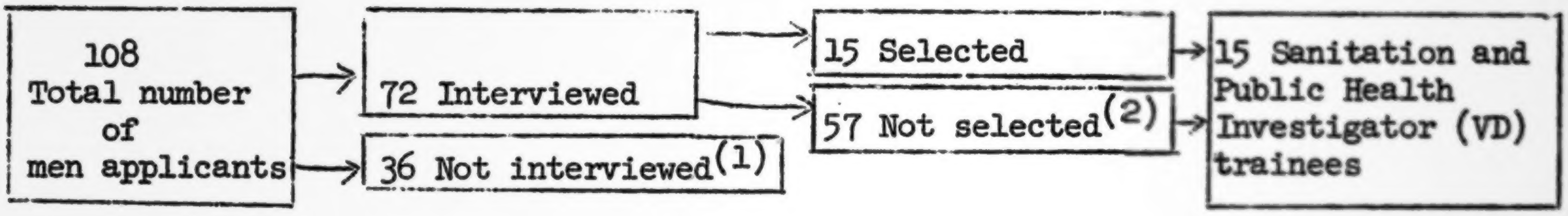
(3) For further information about the characteristics of the trainees selected, see the section on "Selection Process" of this report.

Plans for the third HHA training session were changed abruptly about two weeks before the session was to begin. Applicants were recruited from June 11 into the month of August, when it was discovered that the job market for home health aides was becoming saturated. After an assessment was made of the number of home health aide jobs that were likely to be available it became apparent that there would not be enough jobs for the 120 home health aides which were originally planned to be trained. It was therefore decided to cancel the third HHA class even though 23 applicants had already been selected for this class.

Instead of this class, a group of 15 men health aides were recruited for training to work in the health department sanitation and venereal disease control programs. Details of this class are described in the section on "Special Training and Use of Health Aides". The results of the recruitment efforts to obtain men for this class are shown in Diagram 2.

DIAGRAM 2

Third Recruitment Period
June 11 - September 11, 1967


108 Total number of men applicants
72 Interviewed
36 Not interviewed(1)
15 Selected
57 Not selected(2)
15 Sanitation and Public Health Investigator (VD) trainees

(1) Did not meet the age, income or residence requirements for target areas.

(2) The class was limited to 15 because this was the maximum number of job opportunities available.

The overall results of our recruitment efforts showed that there is a large, and as yet undetermined number of individuals living in the county urban and rural areas who meet the criteria specified and who are interested in becoming trained and employed as home health aides. Although we had difficulty in recruiting men for this position, in total numbers we had more than enough applicants from which to select good students for our two HHA training classes. Accurate figures are not available on the total number of applications received for home health aides during the third period but an estimate of the total number of applications received for home health aides for all three periods from January 1 to September 11 was between 400 and 500.

In addition to this group, applications continued to come in after September 11 as the project proceeded. This was probably due to the fact that the information was being spread by word of mouth by trainees who were already accepted and by other applicants. Persons who were interested in applying telephoned the office for information and such calls were still coming into the office as of December 31, 1967.

Our experience demonstrates beyond a doubt that there is a significant reservoir of available manpower that is interested and that can be trained and employed in the health services professions. The significance of this manpower source becomes greater if the recruitment criteria are broadened beyond those used for this project. For example, if the minimum age requirement were reduced from 45 to 25, the number of persons who would be interested and available to work in new health careers would increase greatly. Likewise, if the maximum income requirement were raised, even moderately, many more persons who want and need a meaningful job would be eligible for employment in health careers. This was borne out in our experience by persons we had to reject because they did not meet the specified age and income criteria.

One conclusion we draw from our experience recruiting for men is that the availability of men for health jobs depends to a significant degree upon the type of job for which they are recruited. For example, we had great difficulty finding applicants for home health aides but no trouble finding male applicants for a training program to employ men to work in sanitation and venereal disease control programs.

Cultural values play an important part in determining what is an acceptable role or job for a man or a woman. For example, even though a need exists for more men to go into nursing or nursing aide jobs, there has traditionally been a shortage of men in these occupations. It should be noted, however, that the three men who were selected and who graduated from the home health aide program are now employed full-time, are doing a good job, and enjoy their work very much.

SELECTION PROCESS

After applications were screened to make sure they met the age and income requirements the applicants were interviewed to obtain further information so that a final selection could be made.

1. Criteria for Selection

In addition to meeting age and income requirements, trainees must have other qualities to be effective home health aides. These qualities are various personality characteristics such as having an interest in working with older sick people, an ability to relate and communicate well with people and being friendly and understanding of others. The staff believed that certain factors should be identified as a criteria for selecting persons for training. The items decided upon were as follows:

Age: 45 - 65

Income: Meet poverty standards. Priority was given to unemployed and welfare clients.

Personal characteristics: Emotionally mature and stable. Understanding and empathic. Friendly and warm. Accepting and flexible.

Physical: No physical deformity which prevents performance of duties.

Residence: Residence in Alameda County. Priority was given to residence in designated poverty areas.

Education: No grade level required. Priority was given to lower level education.

Experience: No previous experience required.

Availability: Available to attend a 12-week training session up to 6 hours per day and available to work as a home health aide at least 20 hours per week.

Health Beliefs: Favorable attitude toward birth control, immunization and fluoridation.

U. S. Citizenship: Required

One of the main desires of the staff in the project was to determine the degree to which older poor people (particularly those coming from the most deprived and disadvantaged backgrounds) could, with proper training, become effective home health aides. These criteria were therefore designed specifically to select persons from the most disadvantaged and "hard core" sections of the community. The assumption was made that there are a great many of these persons who are willing and able to work and if given the opportunity can demonstrate their potential contribution to the fields of medical care and public health. This assumption was proved correct by the results of our evaluation.

2. Selection Methods

It was originally intended to test out two different methods for selecting trainees and compare these methods with the outcome of the trainees. One was an individual interview with the applicant in his home and the other was a group interview with 6 to 8 applicants interacting together in the health department setting.

The individual interview method was the procedure which was being used by the health department to interview other health aides for health jobs. This method consisted of a team of usually 3 department staff members going together to the applicant's home to talk about the person's interest in the job, his qualifications and other items listed in the criteria. The interview team was mixed interracially and was made up of men and women who had experience conducting poverty health programs. This team interviewed each applicant and made recommendations to the Health Officer who then made the final selection.

The group interview method which was proposed for use consisted of getting 6 to 8 applicants together with the same kind of interview team, and then stimulating the group members to talk and interact on key questions and subjects. This interaction was structured in such a way so that individual group members would reveal their attitudes, beliefs, and behavior relating to the job and to other items on the selection criteria. The interview team was thus able to observe individuals as they interacted in the group and could make judgments about their suitability for the program.

The group interview method was briefly tried out and was found to work successfully. Unfortunately it was not tested long enough to make comparisons with the individual interview method.

3. Results

100 applicants were selected between March and June and these were placed in two different training sessions. Of the 100 selected, 83 successfully graduated and were certified. The 17 who did not graduate can be accounted for as follows:

8 never showed up for class. The recruitment staff found on revisit that seven of them were not interested in becoming home health aides. One of the eight had registered and was attending the Home Health Aide Course at a local Junior College.

4 requested dismissal from the course because of mental health problems. Conferences were held with these four students and it was agreed that the extra pressure of attending the home health care course interfered with their ability to handle their personal problems.

1 attended eight weeks of the course, got married, and moved out of the area.

2 had personal problems. One student was referred to the Family Service Bureau and remained under care until she learned that our third class had been cancelled. It would appear she went for counseling because she hoped she could return to class

and become certified. The other student had family problems and although she was admitted to both sessions, she was unable to make adequate plans for the care of her husband and the training staff terminated her.

2 had extremely low reading and writing skills. They were put full-time into basic education and it was our intention to place them in the third training session. Since we cancelled the third class we were unable to certify these two students.

The characteristics of the 83 selected applicants who finally graduated from the two HHA courses are shown in Tables 1, 2 and 3.

TABLE 1

Formal Education by Grade
For Students in 1st and 2nd
Home Health Aide Training Classes

Grade	Number	Percent of Total
4	2	2.4
5	2	2.4
6	1	1.2
7	2	2.4
8	16	19.2
9	7	8.4
10	14	16.9
11	17	20.5
12	13	15.7
Unknown	9	10.8
TOTAL	83	100.0%

TABLE 2

Age of Students in 1st and 2nd Home Health Aide Training Classes (By 5-year intervals)

Age in Years	Number	Percent of Total
25-29	1*	1.2
30-34	5*	6.0
35-39	0	0.0
40-44	3*	3.6
45-49	32	38.6
50-54	21	25.3
55-59	16	19.3
60-64	5	6.0
Total	83	100.0

* 9 of the trainees in the second class were health aides under age 45 who were already working in poverty health programs in the Health Department. They were certified as home health aides but were not paid the stipend while in training.

TABLE 3

Marital Status of Students in 1st and 2nd Home Health Aide Training Classes

Marital Status	Number	Percent of Total
Married	14	16.87
Single	0	0.00
Widowed	21	25.30
Divorced	20	24.10
Separated	22	26.50
Undetermined	6	7.23
Total	83	100.00%

DEVELOPMENT OF THE TRAINING PROGRAM

1. Standards and Requirements

The federal government standards for home health agencies are spelled out in the U. S. Department of Health, Education and Welfare Social Security Administration booklet, Conditions of Participation for Home Health Agencies, March 1966. This booklet states, "The home health agency determines that home health aides receive or have received a basic training program for home health aides". They suggest that the faculty for basic training should be a registered professional nurse, preferably a public health nurse. This booklet also outlines the basic training content, the content of orientation to the home health agency and content of on-the-job instructions. The California League for Nursing, Inc., Committee on Home Health Services in their Guide for the Development of a Home Health Aide Program, May 1966, enlarged on the basic training content outlined in the federal pamphlet. While developing the curriculum, these two booklets were used as guidelines to insure that the curriculum would meet both the federal and state legal requirements.

Before the curriculum was developed reports of home health aide training programs from all over the country were obtained and reviewed. In many cases these reports contained very little about specific teaching materials - only the broad categories of content were spelled out in most of these reports. They were, however, of help and all of them were within the legal limits set by the Social Security Act.

The minimum time requirement for the training program was 120 hours of instruction but the maximum number of hours was not stated. The five basic content categories outlined by the California State Department of Public Health, Bureau of Chronic Disease were introduction to aide and agency role, personal care services, interpretation of medical and social needs of people being served, nutrition, and cleaning and care tasks in the home. We used these five categories as guidelines, developed a training curriculum outline, submitted this to the California State Department of

Public Health from which official certification was obtained for our home health aide training program.

2. Principles of Education Underlying the Training Course

Certain educational principles were followed in designing the home health aide training course. These principles are part of the commonly accepted philosophy held by many educators and trainers - that learning takes place most effectively when it serves a purpose for the student, when it is experiential in nature and when it is presented to the student in a meaningful way.

These specific principles were identified and followed in developing the course:

a. The training program should fulfill a purpose for the student. It must have a specific end in view and the student must perceive these ends to have relevance to his own goals and purposes in life. In this case the end result was a meaningful job. The training provided the ability and the know-how to perform that job.

b. Learning should be experiential in nature. Training must consist of learning experiences which have reality and meaning to the student. Individuals must be able to participate at the doingness level in order to master the specific skills and abilities required.

c. Learning experiences should be programmed in a sequence effective for learning. Students will learn knowledge and skills more effectively if the course material is presented in meaningful units and in a logical sequence.

d. Students should have feedback on how they are doing. Opportunities must be available for students to test out what they have learned. They must be able to determine the extent to which they have mastered the understandings or skills expected of them.

3. Development of the Home Health Aide Training Course

After state certification was obtained a detailed course to train home health aides was developed following the basic principles enumerated above. A systematic approach was used to develop the course and the major steps that were followed are shown in Attachment 2. This diagram identifies each component part of the training program beginning with the listing of performance objectives and follows each step through the process to the end point of evaluating the performance of the individual on the job.

a. Performance Objectives

The first and most important step was to define the job of a home health aide. All of the specific tasks were defined and a detailed job description was developed. See Attachment 3. This was not merely a simple statement of functions and responsibilities but was a list of items which included 64 independent home nursing tasks. These tasks are listed in the attached job description of a home health aide. These activities served as a basis for writing performance objectives for the course.

In developing this job description the state health department requirements were adhered to and a number of job descriptions which were used in other home care training programs throughout the country were reviewed. In addition, the staff of the Home Care Section of the Alameda County Health Department was consulted for their suggestions. The aim was to develop a comprehensive list of activities which a home health aide would be expected to perform on the job.

b. Behavioral Objectives

The next step was to translate the performance objectives into terms which would be more useful for designing the training course. Each performance objective was rewritten as a behavioral objective in terms that were observable and when possible, the conditions of performance that were acceptable. These training objectives stated what the student must be able to do in order that achievement could be measured. An example of one such objective was - the student will be able to demonstrate the proper way to give a urinal to a patient and remove it without spilling its contents.

Describing behavioral objectives in this manner served three important functions:

1. It gave the students a plain statement of where they were going and served as a yardstick to help them check their own progress along the way.
2. It gave the instructors a clear concise goal for their teaching.
3. It served as a standard by which to measure the extent to which the training objectives were met.

c. Lesson Plans

It was the intent to develop organized lesson plans around each behavioral objective and use these lessons in the first course. However, during the first three months of the project much of the staff's time was spent in getting procedures developed, in recruiting applicants and in planning and scheduling the first training course. Because of time delays in recruiting staff and the large amount of effort initially required to plan and organize the project the training staff was not able to develop these lesson plans in time for the first course. Lesson plans were developed as time permitted and the experiences the instructors had during the first course were used in revising the training materials for use later in the project.

A set of lesson plans was finally developed by the end of the second course and these were incorporated into a training manual. A lesson plan was written for each behavioral objective and each plan contained the essential knowledges and skills which the student needed to perform the task. An example of one of these lesson plans is shown in Attachment 4, "Skin Care". Each of the lesson plans contained the objective for the student, an overview with basic information and knowledge required, important new words to know with simple definitions for each, materials required for the task and a step-by-step procedure which indicated exactly how the task should be performed. At the end of each plan were several objective questions which were designed to help the student check his knowledge of key points in the lesson. This simple self-evaluation quiz had the answers on the back page so that the student could check his answers and get immediate feedback.

d. Educational Experiences

The main aim of the training program was to create learning experiences which would effectively teach the required knowledges and skills to this group of trainees. Experiential learning was emphasized and practice situations were created so the students could learn how to correctly handle, manipulate and control the subject matter with which they were dealing.

Consultation was held with various nurses in the health department and suggestions were obtained from the public health nurses who had been working with home health aides as to what was most important to include in the curriculum. The public health nurse who served as consultant to nursing homes on nursing service and who had had experience teaching nurses' aides in the nursing home gave invaluable assistance in making the course basic and practical. The entire curriculum was rehabilitation oriented.

Learning experiences were programmed to occur in order of increasing complexity and responsibility for the students. These experiences began first in a classroom-demonstration-discussion setting, then were followed by a period of closely supervised skills-training with rehabilitation patients in nursing homes and ended with students doing on-the-job training where they provided personal health care to patients in their homes.

Teaching was done in an informal way. The students sat around tables in classroom sessions. The public health nurse instructors, assisted by the senior health aides, presented the lessons to the students. Lesson materials were presented in as simple a form as possible. Ample time was allowed for questions and answers were given immediately.

One of the first and important parts of the training course was the emphasis given to the understanding of basic terminology. This was particularly important in view of the low educational background of many of the students and the difficulty many students had with reading and writing. To insure a greater understanding of a working vocabulary, word lists were prepared for each lesson.

All the medical terms used in the lesson plans which the staff thought would be unfamiliar to the students were incorporated into these word lists. Medical jargon was avoided. Definitions were made simple. If there was a more common word that could be used, that word was selected for the word list. For example, instead of referring to the clavicle, collarbone was used; for coccyx, the tailbone was used; for patella, the kneecap, and so on. The training staff found themselves continually re-defining and simplifying their teaching materials.

Copies of each word list were given to each student and each lesson was begun by going over and defining key vocabulary for the lesson. Technical words were listed on the blackboard, simple definitions were given and any misunderstandings were cleared up before continuing. Sometimes the students were given a word list and asked to copy the definitions from the board. This gave them practice in reading and writing. During this time the trainees required a lot of encouragement and support.

The training course was organized around the technical skills required for the job. After reviewing the experiences of others who had trained the disadvantaged, we felt that the students would learn faster if we had short lectures and more demonstrations and return demonstrations. This was arranged by having an instructor or senior aide first demonstrate the skill, giving an explanation along with the demonstration. Then the students would practice on another student. The instructors and senior aides would circulate among the students and correct any poor techniques immediately. All of the technical skills required for the job were demonstrated in this way. If a student seemed to be having problems, an instructor or senior health aide would help the student immediately. If they needed more individual attention, the instructors would tutor them after class until they were sure they had grasped the material taught in class.

In the classroom the students learned by doing. They learned such things as how to do the clinitest, the proper way to take a temperature and how to read a thermometer. All had an opportunity to practice the technical skills listed in the home health aide job description.

Other disciplines were involved in the teaching whenever possible to help the trainees become familiar with other members of the health team and to make use of their professional knowledge and skills. Examples of other health department staff used were: nutritionist, social worker, physical therapists, occupational therapist, and sanitarian.

In nutrition, practice in menu planning was emphasized since the students were expected to learn how to plan menus and certain therapeutic diets. During each lesson they were given practice in many ways such as to individually and as a group evaluate, plan and write a menu, look at menus by food pictures, and so forth. Practical experience in cooking was limited. The students brought to class custard prepared at home, and the instructor demonstrated cereal preparation. It would have been desirable to provide more practice in food preparation but time and facilities did not permit.

Nursing homes were selected for the second phase of training. The chief nurse on the project together with the nursing home consultant in the department visited seven large nursing homes and selected two for field training experiences. The criteria which they used for selecting the homes was that they have a full-time nursing administration, adequate R. N. supervision of nursing home personnel, sufficient number of patients to give the instructors a good selection of patients for student learning experiences, a good inspection record with no serious violation of the Hospital Licensing Act and requirements of the California Health and Safety Code, interest of the R. N. administrator, a subjective evaluation of the R. N. administrator as to her ability to work with the public health nurse instructors, availability of public transportation so the students with no car could get to the home, sufficient patient care items such as linen, oral hygiene supplies, hydraulic lifts, and a meeting room for brief classroom discussions of patient assignments and demonstration of mechanical devices. In the two nursing homes selected arrangements were made for two weeks of clinical experience for our trainees.

The purpose of the nursing home training was to give the students a chance to practice the skills they had learned in the classroom and to provide a more real life training situation by working with rehabilitation patients. The first day in the nursing homes was a little hectic as many of the students seemed to have forgotten what they had learned in the classroom. Transferring learning from one situation to another was sometimes difficult for students and their initial poor performance in the nursing home seemed to bear this out. Discussions were held in the classroom the next and following days to discuss their experiences in the nursing homes and to review what was expected of them when they were in the homes. They finally settled down and proved themselves quite capable of caring for patients who had conditions such as cerebral vascular accidents, arthritis, heart attacks, and amputations. Patients who were aphasic, senile, incontinent, and who walked with crutches, canes and walkers, were also cared for. Students gave bed baths, tub and shower baths. One of the patients had a seizure in the tub. The student remained calm and supported the patient until help came to get the patient back to bed.

The ratio of students to nurse instructor in the nursing home was one to twelve. However, a senior home health aide was assigned to each instructor and this brought the ratio down to one staff to six or seven students. The senior aides were very capable of supervising a student's technical skills and if a problem developed the nurse instructor was available. The nurse instructor supervised the slower students and those trainees whom she thought would have problems.

While in the nursing home the students got experience using the mechanical lifts in transporting patients to and from the shower and bathrooms. They were able to participate in the occupational therapy group sessions and to do the exercises with the patients. The students grew fond of their patients and many brought the patients a flower from their garden. The patients seemed to enjoy the extra attention the students gave them and were disappointed when the instructors changed student assignments in order to give the student broader clinical experiences.

During their nursing home experience a field trip was planned to a local rehabilitation unit. On this field trip the students were given practical demonstrations in rehabilitation techniques at the hospital's occupational and physical therapy department by the professional staff of the hospital. They practiced falling, helping patients up and down stairs, crutch walking, cane walking and transfer techniques. The occupational therapist demonstrated the kinds of gadgets that could be made to help patients carry on activities of daily living.

The third phase of the training course was having each student provide home care service under close supervision to selected home care patients. For this, the students were assigned home care cases in the community. These were selected from some 380 home health care cases of the Alameda County Health Department Home Health Care Program. The instructors selected cases that would give the students broad experience. The regular home health aide remained on the case and the instructors introduced the student to the case. As the student became more adept at performing the duties of the home health aide she gradually took over the care of the patient. The instructors and senior aides supervised each student in the home at least twice a week. If the student was having problems, daily visits were made while the student was in the home.

Some of the students worked in homes where the standard of living was very low. The housekeeping was very poor and many students had difficulty accepting the family who would live in such "filthy" surroundings. However, after the shock wore off they pitched in and made the place livable. They were eager to do a good job, and to get as much experience as possible. Some students had difficulty finding the patient's home and would call in to verify the address. Some students made a dry run the day before they were scheduled to be at a certain home care case as they did not want to arrive at the case late.

Adequate supervision of the students in the homes by the nurse instructors and senior aides did not present a problem. In a few instances the supervisors were detained in a home because the student was having a problem. This made her late for subsequent appointments but we had prepared the students for this so they did not become upset.

e. Basic Education

Because there was no educational requirement for the course and we were recruiting from the most disadvantaged groups in the community the need for basic education was acute. Many of our students had dropped out of school at an early age and the great majority had no formal education or training experience beyond their elementary schooling.

Assistance was provided by the City of Oakland Adult Education Department. They provided an adult education instructor at no expense to the project. With help from the project staff he developed a basic education class which was integrated with the home health aide training. The integration of the basic education instruction with the technical skills training was a unique feature of the program. The main purpose for this was to insure that the reading, writing and mathematics instruction would become as meaningful and important to the students as possible.

On the first day of class the students were given the Wide Range Achievement Test to determine their reading grade level. All students who obtained a reading grade score below the 8th grade level were placed in the basic education class. Several with higher grade levels were included to give them help in special areas. The reading levels in these classes ranged between the third and eleventh grade levels. 18 of the students in the first HHA class and 35 of the students in the second class were placed in the basic education classes.

The basic education class was developed by taking the teaching materials used by the nursing instructors and adapting it to teach reading, writing and mathematics. Everything taught was aimed at the job. All of the subjects, concepts and exercises were meant to have significance for the students. The usefulness of many of the reading and mathematics skills became evident to the students when presented in this manner.

Some examples of how this integrated teaching took place are described. Fractions and decimals were taught as they related to handling money, reading the clinical thermometer and recording fluid measurements. The mathematical concept of place value was taught using an odometer and figuring car mileages. Phonics and syllabication lessons were developed around the nursing vocabulary the students were learning. Weekly written reports by the students to the HHA training staff provided opportunities to work on many aspects of language and writing skills. If a student was having problems reading a thermometer and recording the temperature in tenths, the teachers used this information to develop an exercise in the decimal system. Keeping time cards gave the students practice in subtraction. To help the students get to the homes of patients on home health care assignments map reading was taught.

Some of the practical and job oriented materials which were used for teaching included home health aide lessons and word lists, health education pamphlets, dictionaries, city and county road maps and transit system maps. Most of the instructional materials were created by the teacher for this basic education class.

Much of the mathematics was individualized. No text or workbooks were used to teach mathematics. Worksheets were made up daily for five different achievement levels. These worksheets were given to the students and were collected, corrected and returned and individual help was given whenever needed. Personal help was given to the student daily if time permitted. Lengthy presentations and lectures were avoided. The students worked together and helped each other in the classroom.

Great effort was made by the basic education teacher to devise student exercises that would not defeat or frustrate the students. All assignments and worksheets were designed to give a high level of success. In some cases worksheets were developed to assure the student getting a grade of 90% or higher. Many quizzes were designed primarily to teach and provide immediate feedback of success. All worksheets were corrected and returned within one day. The instructor and an aide circulated among the students as rapidly as possible whenever worksheets or assignments were being done.

The staff felt this was one of the most important phases of the whole training program. The students were very enthusiastic about the basic education class. For some of the trainees their progress in basic education may have been even more important than the HHA training per se. For results of the basic education training see the later section on "Results of Training". Since most of the basic education skills and concepts taught aided the students with their vocational training the students were as highly motivated in this class as they were in the HHA training. We think this experience demonstrates the tremendous need for basic education using these techniques when dealing with this kind of population group.

f. Development and Use of Training Materials

The training staff made an extensive search for training materials that would be suitable for teaching the classes. Existing materials such as films, filmstrips, charts, models and manuals were screened to determine their suitability. Many movies and film strips were previewed but there were very few films that were available for use with our students. Many were too technical for the students and the ones we thought were appropriate were not available. The films the National Red Cross had developed to teach home nursing proved to be the most useful. They were available from the local Red Cross office.

There were no manuals written specifically for home health aides. We reviewed the manuals written for nurses' aides, the Red Cross Home Nursing Manual, licensed vocational nurse manuals and manuals written for registered nurses. In some we found good illustration materials which we had our graphic artist adapt to our level of students.

Because there was no manual written specifically for home health aides, we decided to develop one. The lesson plans which were developed during the first sessions were revised and compiled into a manual for training home health aides.[1] These lessons were grouped according to instructional units and a section on "Important Words to Know" was included. Illustrations were developed and included to clarify complicated procedures. This manual was intended to be used to teach the third class trainees, but this class was cancelled. The manual will be used for the in-service training of health aides in the Alameda County Health Department or can be used as a resource for other agencies doing similar training.

An instructor's guide[2] was also developed along with the student's manual. This guide was designed to help an instructor teach a home health aide training course. It lists suggestions which the project staff found helpful in teaching various parts of the course. It also describes supplies and materials for conducting demonstrations, films and other visual aids and general reference materials which were found to be helpful.

In addition to the two manuals, the staff developed a number of specific teaching aids which were used effectively in the classes. These included word lists, illustrations, flannelgraph and transparencies for projection.

Word lists were developed for each lesson and given to each student. The senior health aide assigned to word lists duplicated the word list on a hectograph and it was her responsibility to see that the instructor was supplied with the proper word list and the correct number of copies for the lesson taught that day.

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[1] Home Health Aide Training Manual, Home Health Aide Pilot Training Project, Alameda County Health Department, 1967

[2] Home Health Aide Training Manual, Instructor's Guide, Home Health Aide Pilot Training Project, Alameda County Health Department, 1967

Appropriate visual aids were searched out. We attempted to illustrate most of the lessons with pictures. We found many good visual aids in the rehabilitation booklets, Strike Back at Stroke,[1] and Up and Around.[2] We transferred these pictures to mats and mimeographed copies for the students.

The project staff made a flannelgraph of a man out of felt. Each body system was cut out of felt and could be stuck onto the felt man to give the student an idea of the location of the organs. As the instructor taught about the respiratory system she placed the organs in the proper location. This was very helpful to the students as many had a very hazy idea of the anatomy of their bodies.

Body mechanics were difficult to teach. We had the graphic artist from the health department make drawings to illustrate the rules of good body mechanics. We then had them transferred to transparancies and planned to use these during the third class. One of our problems was lack of time to develop visual aids. The overhead projector would have been helpful, but we did not get it in time to use with our first two classes. We do plan to use it with the transparancies we developed for continuing in-service education of employed home health aides.

g. Mechanics of Training

The facilities used in the headquarters building of the Alameda County Health Department were not adequate. The classes, both basic education and home health aide training, were held in the multipurpose room. This room was very large, 64 by 48 feet, and could be partitioned off into seven smaller rooms. The movable partitions, however, were not soundproof. It was noisy and crowded and difficult at times to hold the students' attention.

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[1] U. S. Dept. of Health, Education and Welfare, Strike Back at Stroke, PHS, Washington 25, D. C., 1958

[2] U. S. Dept. of Health, Education and Welfare, Up and Around, PHS, Publ. No. 1120, Washington, D. C. 1964

The laboratory set-up consisted of four hospital beds and four bedside stands completely equipped with the necessary patient care items. We borrowed the hospital beds and bedside stands from Fairmont Hospital. The necessary patient care items were purchased with project funds. The laboratory was small so when students had laboratory practice we would use two of the rooms and push the beds and bedside stands into the next room.

Linen was a problem. We had purchased 48 sheets, 12 pillow slips, 24 bath towels, 12 washcloths, 2 bathrobes and flannel to make 8 bath blankets. With our large class we would always run short of linen. One instructor took the bath towels, washcloths and bath blankets home with her each night, washed and dried them and returned them so we would have linen for the next day's laboratory practice. The health department has a method of getting this kind of laundry done but it took a week to get it back. We were not able to wait that long.

There was no running water in our laboratory, but there was a bathroom nearby. We carried water into the laboratory with pitchers and carried the dirty water into the bathroom for disposal. Even though this was not convenient it did simulate home conditions and taught the students to plan their work accordingly.

The project staff became adept at improvising and borrowing. The public health laboratory supplied Petri dishes for soap dishes. They loaned us basins and pitchers. From the clinic we borrowed ring stands, pitchers and basins. The classes were large and we had underestimated in our ordering of patient care items so we had to borrow equipment.

The two convalescent hospitals we used for clinical practice gave us a good selection of patients. The instructors were oriented to the convalescent hospitals a week before the students were scheduled for this experience. They met the staff, familiarized themselves with the facility, visited the patients, reviewed the rand and introduced themselves to the charge nurse of the wing where they would be working. A few days before the students went into the convalescent hospital the instructors carefully selected the patients to correlate lecture and laboratory with the nursing home experience.

An assignment sheet was made out for each student. The patient's name, diagnosis, nursing care plan and likes and dislikes of the patient were entered on the worksheet. In the briefing session the students were given this worksheet, each patient was discussed and then the students were taken up to meet their patient. While the students were taking care of patients the nurse instructors and senior aides observed the students, gave help where it was needed, demonstrated and explained procedures and soothed nervous students. When the students had completed their assignment they gave a written and verbal report to the instructor. The instructors in turn gave a written report on the patient the students had cared for to the supervising nurse of the convalescent hospital.

We felt that the experience the convalescent hospital provided for the students was adequate. The nursing care was not optimum and the nurses aide staff, for the most part, had very little training but the students were given the opportunity for a variety of experiences. Patient care items such as soap, toothbrushes, shampoo, lotion, nail files and clippers were sometimes not available but each instructor had a "goody bag" outfitted with the above items and used them when necessary.

The classes were scheduled for eleven week periods. Most of the students desperately needed and wanted basic education. Therefore we divided the class in half and had A.M. and P.M. home health aide classes and A.M. and P.M. basic education classes. The students were attending class six hours a day and were tired at the end of the day. If the student missed class it was almost impossible for her to make up the time. Also, the nursing home experience had to be in the morning as both nursing homes had a policy that all patient care must be completed by 10:00 A.M. However, by previous arrangement the students could work until 12:00.

After the student had finished her clinical experience for the day she came back to the health department for basic education. Bus transportation to and from the nursing home was adequate so the students had no problems in getting from one place to another. We had some problems in scheduling the use of health department staff for teaching.

Classes taught by the nutritionist, occupational and physical therapist had to be scheduled long in advance to fit into their schedule for other commitments in the health department.

The part-time social worker was on duty Monday and Thursday for the first class and Monday and Wednesday for the second class so her classes had to be scheduled on these two days. We could have used the social worker in many of our classes but she was only available to the project half time.

With all the limitations and difficulties we had in scheduling, the instructors used every possible moment to squeeze in conferences with students who were having problems. The instructors were so busy preparing for their next class, teaching, holding conferences with students, correcting papers and notebooks, preparing quizzes and writing lesson plans that little time was left over for staff meetings to iron out some of the interpersonal problems and misunderstandings that developed.

The classes were too large. We did not have the facilities for such a large class. Slower students could not be given enough individual attention because of our inability to find time or space to hold special class sessions. Some of the faster students became bored and if we had had another classroom, they could have graduated sooner. Then too, none of the instructors had prior teaching experience, but they did have experience working with small groups. This carried over in working with the larger group as the students were eager to learn, brought a great deal of "common sense" into the classroom and participated in class discussions. The instructors accepted the students, liked them and were interested in them. The students seemed to sense this and asked questions when they did not understand, even though some students in the class verbally told them to be quiet. The students knew the instructors would answer their questions and would not embarrass them by the answers.

Teaching techniques were varied. This was very important in maintaining interest. However, because of the large classes, trainees were sometimes overlooked if they never voluntarily participated. Their inability to perform was first picked up in the nursing home when they were unable to care for the patients assigned to them. At this point they were brought back into the classroom to practice skills until they were able to perform adequately.

In the second session the students were divided into two groups according to reading levels. Each group was assigned two instructors who had primary responsibility for their class. Each instructor then selected 12 students and she worked with them throughout the remainder of the training class. This helped the students relate to one instructor and facilitated a closer working relationship between student and instructor. It also enabled the instructor to know the student's capabilities and to plan for adequate supervision in the nursing home.

Eleven weeks' training seemed to be adequate for the majority of the students. It would have been helpful if we could have held more of the students over for extra training. The training staff felt the students, with supervision, could carry out the technical skills, but needed more training in the emotional and psychological aspects of illness. They also needed a greater understanding of supervision. Criticism seemed to mean personal failure to them. This was borne out by the performance evaluation.

However, we were able to adjust the length of the class for some students. One student in the first class was held over for a month to make up the time she had lost and the classes she had missed because of illness. Seven of the students in the second class were given one to two weeks extra training because they were deficient in certain areas. One student, because of mental health problems, was suspended for 3 months. Upon receiving a favorable psychiatric report, she was given a month's trial period as a home health aide under close supervision and was certified upon completion of the trial period.

h. Training Staff

The importance of a good training staff cannot be overemphasized. One of the most important qualities in the training staff was personal commitment - a belief in the ability of the disadvantaged poor to be trained. The nurse instructors had to have patience, enthusiasm for the job, be extremely flexible, be able to work with people, have some awareness of the problems of the poor, know the community facilities and to be able to work under pressure.

The chief nurse, the three supervising nurses, and the three senior aides were selected because of the above qualities from the regular staff of the health department. Although the project called for a Ward Nurse II we were able to employ a public health nurse in this position.

Not all the staff were appointed at the same time. As workload increased additional staff was added. The project director, the administrative assistant, the chief nurse, one supervising nurse, the public health representative and a Stenographer II were appointed soon after the beginning of the project around the first of February.

Other staff were added as follows:

3 Neighborhood Health Aides	March 6
Basic Education Teacher	March 6
Staff Nurse II	March 13
Steno II	March 27
Supervising PHN	May 1
Social Worker	April 4
Supervising PHN	June 26
Sanitarian	July 1

Little time was available to orient and train the project staff. They were expected to do the job without additional training. Those who came to the project after the classes started, were immediately involved with teaching and supervision and had little time to get oriented except to read minutes of previous staff meetings and the project write-up when time was available. Planning meetings were difficult to hold as instructors were involved with students 6½ hours a day. However, as a nurse instructor was added she pitched in and did the job she was expected to do to teach and council students.

The three senior aides on the project were very helpful. They had been selected because of their prior ability and experience as home health aides. They served effectively to bridge the gap between the trainee and the instructor. They assisted the instructors in the classroom, supervised trainees as they gave demonstrations, assisted the students during examinations, and when the student was having problems could, in many cases offer support on a closer emotional level than could the rest of the staff. They also supervised the students in the nursing homes as it was impossible for one nurse instructor to give the necessary supervision the students needed when working with patients.

They worked well on the project and could be a valuable part of staff for all similar programs. They also provided observable proof of the "new careers" philosophy which added meaning to the program for the trainees.

Although the senior aides were very helpful on the project there were many frustrations and problems. A job description was not written immediately and the instructors and aides were often not clear as to what each should be doing. They were appointed to the project after the first class had started and had not been involved in the planning. Although they were under the supervision of two of the public health supervisory nurses they still felt insecure because they had no definite schedule of their job responsibilities and they often did not know what to do. They needed much support, encouragement, and compliments on what they were doing well but the supervisors were busy teaching and could not always give the kind of supervision they needed.

There were drawbacks with using some of the non-project staff instructors because they were not oriented toward teaching. Some of these were the physical therapists and occupational therapists. Some were unable to make their presentations simple and easy to understand. Often there were communication problems between the trainees and the guest instructors. Unfortunately for each lesson involving a physical therapist, a different person came to present the lecture and demonstrations. This did create some duplication and also prevented a therapist from really becoming involved with the trainees or even the instructors.

We feel many of our problems could have been avoided if the entire teaching staff could have been employed at least a month before classes started. In writing the curriculum, areas where the senior aides unique skills could have been used could have been programmed into the lesson plans. Then a definite schedule could have been planned and the senior aides would have been able to plan their own work.

During the project we had two part-time social workers. The first was not able to continue on the project and so we hired another. Both were of great assistance to the teaching staff and the students. We had great difficulty in recruiting a social worker with the training and experience we wanted. It would have been helpful to have a full-time social worker with extensive training and experience in group work and counselling. We could have used her skills as a group leader in almost every lesson we taught. Group counselling would have been helpful to all the students and perhaps the problems we encountered with trainees not being able to accept supervision could have been worked through while they were in training.

The number of persons on the training staff was adequate and for the most part worked well together. There were some problems in communication but these were solved through special conferences.

INDIVIDUAL PROBLEMS OF STUDENTS

During the training course, many students had individual problems for which they needed help. The nature of the problems consisted of a wide variety of difficulties. Some of the students had personality problems such as lack of self-confidence, fear of failure, communication difficulties and chronic tardiness. Others had emotional or physical health problems that needed attention. Some had financial, family, and other troubles to cope with, such as child care problems, transportation and court appearances with older children.

The staff endeavored to help the trainees cope with their problems in two ways -- through individual conferences and by the use of group counselling.

1. Individual Counselling

   The public health nurses on the training staff had previous training and experience with individual and family counselling and they were able to help the students work out many of their problems. The social worker was also available to help when necessary. The staff worked closely with the Welfare Department, Family Service Agency and other community service agencies in making referraals for special help.

   The instructors held frequent conferences with the students, assuring them that they would pass the course. Many students lacked self-confidence in the beginning and needed continuing reassurance that they could do a good job and would pass the course. The basic education teacher gave them extra help if they were having problems reading the material. The nursing instructors gave the basic education teacher lesson plans and sample test questions, and he would use these as a basis for his individualized lesson plans for a particular student who was having problems. Most of the students' fears of failure were overcome by devoting special attention to their needs, getting them to succeed in small ways, and reassuring them of their own abilities.

Many child care problems were solved by counselling the mothers to put their children in child care centers. Even though most of the students had lived in Oakland for many years, many did not know that these child care centers existed.

Serveral trainees had problems with their older children and had to be absent from class to appear in the probation office or in court. Some of their children's problems were traffic violations, stealing and truancy in school. We encouraged the mothers to work with the probation officers and excused their absences for these reasons.

Most of the financial problems occurred before the student received his first pay check. Because of the County policy of once-a-month pay, the students did not get their first check until four to five weeks after beginning the class. This meant they were in class at least a month before they received a check. Some had funds to tide them over this period but most had very little or no money at all. We referred these to the Welfare Department for help. If this did not help we referred them to the Community Service Center where they could borrow money and pay it back when they received their first check. Some of the students moved into cheaper quarters and managed to scrape along until they were paid. Although many were hard pressed financially, none of the students dropped out because of financial problems.

Money for transportation was a problem for some of the students. Prior to their first pay check, bus tokens were given to the students if they were missing class because of lack of money for transportation. We bought the bus tokens out of petty cash. The students were able to manage after they were paid.

Several had medical problems and were not under care. We were able to get most of these students under Highland General Hospital Clinics or under

Medi-Cal. Since the project had very little money for medical care, we used existing facilities in the community to get the needed medical attention for the students. Most of the students had multiphasic exams and follow-up physicals. Those who did not had had a physical within the last six months and we requested the report. One student had undetected diabetes. She was referred to Highland General Hospital and went under treatment. Several had high blood pressure and were treated for this by the physician who performed the physical examination. One student failed the vision examination. She was sent to an ophthalmologist. The examination and the glasses prescribed were bought with treatment funds from the project. Many of the women were over-weight and had high cholesterol levels. The nutritionist in her classes discussed proper diet for the students as well as the patients with whom they would work. The nursing instructors also discussed diet in the lessons on personal grooming.

After some problems began to come up over and over again with some students, the training staff thought they should develop a list of conditions which would provide a basis for determining a student's termination from class. These conditions were discussed thoroughly with the students in order that they would know the expectations of the staff and the reasons why we felt it was important to maintain certain standards of behavior to remain in the class. It was our intention to take a firm stand on maintaining certain work standards, but at the same time to provide as much help as possible to each student having problems. One of these problems was chronic tardiness. When we threatened to not pay them for the time missed more managed to get to class on time.

The criteria which was developed for determining termination from class was:

a) Inability to attend classes regularly and on time. If a student misses three days in a row, he or she will be referred for follow-up. If the student is absent, the reason must be known.

b) Inability to learn - as demonstrated by no progress within one month.

c) Inability to relate to patients.

d) Own decision that they do not wish to continue in the program.

e) Physically unable to do the work.

f) Medical condition found on physical examination - physician recommends student be dropped from program.

g) Serious medical condition which would necessitate postponement of attendance more than three months.

h) Refusal to take basic education classes if unable to read or write at level required for job.

Whenever a trainee was thought to have a problem in any of these areas, it was discussed throughly with her by her nurse-instructor or social worker in order to help the student resolve it. Students were sometimes referred to other agencies if the health department was not able to assist. Although the criteria was seldom used to terminate students, it did help to improve some of their poor work habits such as arriving to class late and unexcused absences.

2. Group Counselling

In the second class session, some of the students had serious problems with tardiness, withdrawal, overaggressiveness and problems with authority. It was decided to conduct a series of group meetings where these students would have a chance to gain more awareness of their own behavior. The objectives for the group were:

a) To provide an opportunity for the students to express their feelings about the course and about being a home health aide.

b) To identify problems the students were having.

c) To enable students to share in the exploration of problems and possible solutions.

d) To encourage positive feelings of worth, self-respect and identification with the role of home health aide.

The group was led by the project social worker and two senior health aides. The role of the staff was to be as accepting and non-threatening as possible, to guide but not direct and to help the students think as much as possible for themselves.

The instructors and the three senior aides selected 10 students to participate in the group. The instructors explained to these students why they were placed in the group, but the students did not fully realize the purpose for the meeting until their second session. After the second group meeting the students realized that they were in the group because they had problems and not because they were the outstanding students in the class.

Even though the instructors had explained the reasons for the group meetings, the students did not become fully aware of the implications until the social worker started to discuss the very problems that put them in the group. At first they were reluctant to talk. They resented talking about themselves. After the second group meeting, some of the group members became quite disturbed and some of the students circulated a petition to fire the social worker. Several of the students felt they had been attacked in the group. The instructors and senior aides wanted to cancel the group. They reacted negatively because they were unaware of what had taken place in the group meeting. The two senior aides who had been assigned to the group had been unable to attend because of illness and car problems.

Another group meeting was therefore held immediately, and the social worker was able to get the students to talk about their feelings of being in the group. The group decided that attendance at further group meetings would be voluntary. Only one student decided not to attend the group sessions and she later dropped out of the course. After several sessions, the members began to open up and talk. Eventually, many of the students' problems were discussed and most of them gained more ability to cope with them.

The senior health aides were very helpful to the students in these groups. They were able to empathize and discuss their problems openly with them. The aides were also able to give the students the necessary support in the group. One of the senior aide group leaders wrote in her final evaluation of the group session: "This situation (the small group) provided an opportunity to express feelings about being a home health aide, (it) also provided opportunity to identify problems, share in exploration of problem solutions and (was) able to encourage positive feelings of self-esteem, self-respect, and identification with the role of a home health aide."

Some of the instructors and senior health aides were dubious about the value of the group sessions. They thought it was threatening to the students, that it did not help the student, that the students resented being placed in the group and that individual counselling was better. In spite of the negative reactions and some stormy group sessions many of the group participants felt they had benefited from this type of experience. One of the participants told a staff member at graduation that she didn't have to be the problem child any more as she knew she could be a good home health aide.

In Attachments 5, 6 and 7 are two reports of group counselling sessions written by the social worker and excerpts of reports written by two of the senior health aides. These reports are examples of descriptions of the procedures used and some of the observed behavior of the group members.

RESULTS OF TRAINING

The results of the project were measured in four different ways. The first was an evaluation of the knowledges and skills learned by the home health aide students at the end of the course. The second was the number of students who were graduated and were certified as competent home health aides. The third measure was a performance evaluation made on a selected group of trainees who had been working on the job for 15 weeks. The fourth area which was evaluated were the gains made by the students in reading, writing and mathematics as a result of the basic education classes.

1. Knowledge and Skills Gained During Home Health Aide Training

The project was not designed to test students before and after class on home health care knowledges and skills. Before and after testing would have given a more accurate measure of learning acquired during training, but there are several reasons why this type of testing was probably not advisable even though the project had been equipped to do it.

First of all, an accurate measure of how much a person knows as a result of or at the end of a course does not indicate, necessarily, how well the person is able to transfer these learnings to the work situation. A person's ability to make a high score on a test is a result of a number of factors including understanding the content, skill in memorizing, knowledge of the language and terms used, ability to decipher the test and to work under pressure. Our students lacked many of these skills because of their backgrounds and experience. Tests, therefore, are not necessarily an indication of how well a person is able to perform satisfactorily on a job.

Secondly, the experience of our project has shown that this type of testing with disadvantaged or ethnic groups is very difficult and must be done very carefully to show valid results. Most of the trainees in class appeared apprehensive and threatened by tests of any kind. Tests were viewed by many as a threat or barrier to their job and if they did not pass the tests they felt they would be out of the class and out of a job. As a result there was a great deal of anxiety expressed over any kind of test. Other difficulties were that the technique of testing was new or strange to many persons whom we recruited and they had difficulty understanding how to take them; the test language is often different from the cultural group being tested and not understood by them; and some items on knowledge tests have little or vague relationship to the skills being learned and the job that must be performed.

The tests that were finally used were developed and administered keeping the above factors in mind. The training staff felt that giving small, simple and frequent quizzes to the students would be more helpful as a learning device than as an evaluative tool. Our staff felt strongly that it was important for our students to learn how to take tests and to be able to cope with them without too much fear and anxiety. Regardless of the validity of testing as a measure of job ability the testing procedure is a universal one among most civil service and government agency systems and the ability to take a test is an important skill to master in order to compete successfully in the present day job market. Testing of students in the project was therefore approached from this viewpoint. We discussed our basis for giving tests with the students and explained to them that tests would be given mainly for their benefit so that they would be able to check their progress along the way and that they would develop a better ability to take tests. It was clearly pointed out that the tests would not be used to flunk them out of class.

The students responded well to this approach. Frequent quizzes were held and these were explained ahead of time. The questions were composed to assure that the students would get most of the answers correct. The quizzes were effective only when the questions were well understood ahead of time. We found that a short, simple quiz after each lesson was more helpful to the students than just one or two tests during the course. The use of grades did not seem to be effective as they all seemed to think they deserved an "A." They seemed so concerned with comparing grades that they overlooked what we were trying to teach. If they did not get an "A" they were so upset they seemed unable to benefit from the day's class. Therefore quizzes were used, corrected and returned ungraded, and then discussed in class.

A "final examination" was prepared and given to the students at the end of each HHA class. This examination was composed of 51 questions which were taken from the Test Reservoir for Aide Instructors in Nursing, "TRAIN", developed by the National League for Nursing.[1]

"TRAIN" is a test composed of 200 objective multiple choice questions on knowledges needed by nursing aides working on adult clinical units in general hospitals. The test items were designed to be used in their original form or to develop other tests for special needs. The test was reviewed and those items that were appropriate for home health aides were selected for our final examination. Some of the original questions were rewritten in simpler terms so our students could understand them better. The HHA knowledge test is shown in Attachment 8.

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[1] Test Reservoir for Aide Instructors in Nursing (TRAIN), National League for Nursing, Evaluation Service; 10 Columbus Circle, New York, 1965.

The test was explained fully before it was distributed and the instructors and the senior health aides helped the students take the test. If an individual appeared to have difficulty reading the questions, one of the staff would paraphrase the statement until the student would understand. No time limit was placed for completing it. Most of the students did very well in the quiz and all obtained satisfactory scores on the results.

In addition to a knowledge test it was thought important to develop an instrument to measure home health care skills. To develop such a measure several evaluation instruments which are used in rehabilitation settings were reviewed. These instruments are commonly called "activities of daily living" check lists and are a way of rating a patient on his ability to perform common everyday activities. From the categories and items used on these forms, plus ones which we added to measure home care skills, we developed a Performance Check List. This is shown in Attachment 9. This form contains all items of behavior which are essential for a home health aide to perform satisfactorily on the job. Each trainee can be rated on their performance by an instructor or supervisor.

We intended to use this check list as a final performance evaluation for each student at the end of class. We were unable to use it in this way for several reasons. First, it was too long and detailed and took too much staff time to complete. Secondly, it was difficult at one time to rate a student on all the items since most require patients on which to perform health care and it was never possible to get enough different kinds of patients at one time so that all of the activities could be performed.

Thus the check list did not prove to be a practical final evaluation measure. Instead it was used by the instructors and senior health aides as a guide to train the students in their nursing home experiences and to "check out" the students on learning various categories of home health care. The check list was also useful in developing a simpler evaluation form which was later used to evaluate performance on the job. This is described in Item 3, of this section.

A final and purely subjective evaluation of the courses were written statements which individual students were asked to make. At the end of each course students were asked to write a statement in her own words about what she got out of the course. It is difficult to evaluate the meanings of these statements in terms of training outcomes except to say that without exception all students expressed positive emotional feelings about what the training meant to them personally. Representative comments were selected from these statements and they are reproduced in Attachment 10.

2. Number of Students Graduated and Certified

The second measure of outcome for the training project was the number of students who successfully graduated and were certified as home health aides. The total number of persons who were selected for both classes was 100. Of this total 83 graduated or successfully completed the course. 15 of the 17 who did not graduate were terminated at various times during the courses for reasons described in the section on "Selection Process" - i.e., 8 never showed up for class, 4 dropped out at their own request for mental health reasons, 1 married and moved away, and 2 were terminated by mutual consent for personal and family problems. The remaining two of the 17 persons were the only ones who were not able to graduate because of scholastic ability. Both of these students had extremely low levels of reading and writing skills. They were at the lowest end of the class with reading grade levels of 3.7 and 4.6. They were not able to sufficiently grasp the material being presented and could not keep up with the rest of the class. It was decided to put these two persons into basic education full-time until they had developed enough reading, writing, and mathematic skills to get back into the HHA class. It was our intention to put them into the third HHA class and give them special help. If the class had not been cancelled they might have graduated from this class.

The final results were that 83 or 98%, of the 85 students who remained in the two HHA classes graduated successfully.

3. Evaluation of Performance on the Job

The most valid way to test for effectiveness of a training program is to measure the extent to which the trainees are performing on the job the skills which have been taught in the course. Such a performance evaluation was made on a selected group of individuals.

Thirty-seven students graduated from the first HHA course on June 23, 1967. Of this group 24 were employed part-time the week after graduation. An evaluation was made on this group 15 weeks after they were employed. Most of this group of 24 were employed approximately half-time. The average number of hours worked per week for the group was 22. The average number of days worked from graduation until time of evaluation was 76.

The evaluation procedure consisted of developing a performance check list which would be given to the nurse supervisors of each of the 24 home health aides. The supervisors judged each aide on 30 items of job behavior and rated each item on a three point scale.

A performance evaluation rating sheet was developed. See Attachment 11. Our aim was to create an instrument that would measure all the major activities and behaviors that are expected of a home health aide on the job.

The intent was to develop an instrument which would be reliable and valid and still be practical enough to be used by the nurse supervisors in the field.

Using as a guide the detailed Performance Check List (Attachment 9) which we had developed earlier and the behavioral objectives which we used for the training course and the training manual we arrived at a list of 30 items of behavior. Each of these items covered a significant part of the training and job performance and each could be observed by a supervisor. The items represented one of three important work skills: technical home care skills, work habits, and interpersonal relations skills. These were assembled onto one page into a rating instrument with a three point scale for each item. The supervisor could rate each aide on each item according to whether it was performed most of the time, some of the time, or seldom.

This rating sheet was then tested with some of the nurses and health aides in the department to determine if the items were appropriate ones, and whether it was understandable and workable. After a few minor revisions in the wording and arrangement of items, it was completed.

Copies of the rating sheet were sent to all of the public health nurses who supervised any of the 24 home health aides. The nurses were instructed to rate the aide on each item. We also enclosed a copy of the detailed Performance Check List and asked the nurse to use this as a guide for determining what she should consider in evaluating performance on an item.

Each nurse completed an evaluation form on the aide she supervised. 19 of the project home health aides were being supervised by two or more public health nurses and only 6 of them had one nurse supervisor. As a result, 65 completed evaluations were received for the 24 students. In almost every case the nurses were able to rate each aide on most of the items. The last item on overall functioning was added to find out how the nurse felt the aide was functioning in general, particularly if the nurse had given low ratings on one or more items.

The reliability of the rating scale appeared to be fairly good. On each of 12 of the aides three different nurses turned in an evaluation. In one case, four nurses evaluated separately; and for two aides, six different nurses rated them. These multiple rating sheets were examined and the degree of agreement between the nurse raters on individual aides was very high. The most variation that occurred was on the behavior items pertaining to communication and interpersonal relations and professional behavior. These activities are by nature more difficult to evaluate than technical nursing skills.

The results of the evaluations were analysed in the following manner. The rating sheets were reviewed to determine how many items were not rated. These items were examined and if 20% of the supervisors did not rate on an item it was removed from the final analysis. There were eight of these items: "Takes care of patient's mouth and teeth", "Shampoos and combs patient's hair", "Able to dress and undress paralyzed patient", "Knows how to give patient bedpan or urinal", "Encourages patient to move in bed", "Gives a safe shower", "Gives a safe tub bath", and "Handles Emergency situations". We learned that these items were left blank so often either because of the relatively few number of rehabilitation cases which needed this type of care or because the nurses were not able to observe this activity during the time it occurred.

Those items for which no ratings were given by 20% of the nurses or less were not removed. For these an intermediate score (some of the time) was arbitrarily assigned in order to use as many of the items for analysis as possible. It was assumed that arbitrarily assigning an average or intermediate score to an item left blank was justified since the chances of the aide receiving a score in this column were greater than in either of the other two extreme categories.

Of all the items on the 65 evaluation sheets which were completed there were only 15 instances that the "Seldom" rating was marked. Of these 15, 7 were items marked for one individual.

Numerical scores were arbitrarily assigned to each rating in the following manner:

No. of Points	Rating
1	"Seldom"
2	"Some of the time"
3	"Most of the time"

A point score was thus assigned for each item for each aide. In cases where more than one evaluation was made on an aide the item scores were totaled and an average item score was computed and assigned.

After excluding 8 items for which inadequate responses were available there remained 22 items of behavior for which we had scores to evaluate the home health aides' performance. These 22 items were then rearranged and grouped into three logical categories.

Items pertaining to technical skills were grouped together, items relating to professional conduct and work habits were grouped together and those items having to do with attitudes and interpersonal relations were placed together. The item on overall functioning of the health aide was not included in these groups. See Attachment 12 for the final grouping of these items. After analyzing the items in groups it was decided to give group scores for each aide.

The results of the evaluation were very encouraging. The overall evaluation as determined by the totals of the group scores indicated that all of the aides were functioning in at least a satisfactory manner. The range of total scores that was possible for an aide to obtain was from 22 - 66. The actual range of scores was from 53.5 - 66. On overall total scores all of the students fell above the 72nd percentile. (See Table 4)

The results of the scores on the general item supported this conclusion. For all aides except one, ratings were checked "Most of the Time" by nurses for the item, "In your estimation is this home health aide functioning in a satisfactory manner?" The one exception was an aide who was having difficulty functioning adequately on the job and this was borne out both by her total score which was the lowest of the group and by a rating on "Some of the time" to the overall functioning item. In retrospect the training staff noted that this particular aide had been a problem in the training class and they felt she should have been counseled out of the course for reasons of instability and emotional problems.

The results of the scores by groups of items can be seen in Tables 4 and 5.

76

Table 4

Performance Evaluation of 24 Home Health Aides

Range of scores and percentiles shown for totals and groups of behavior items

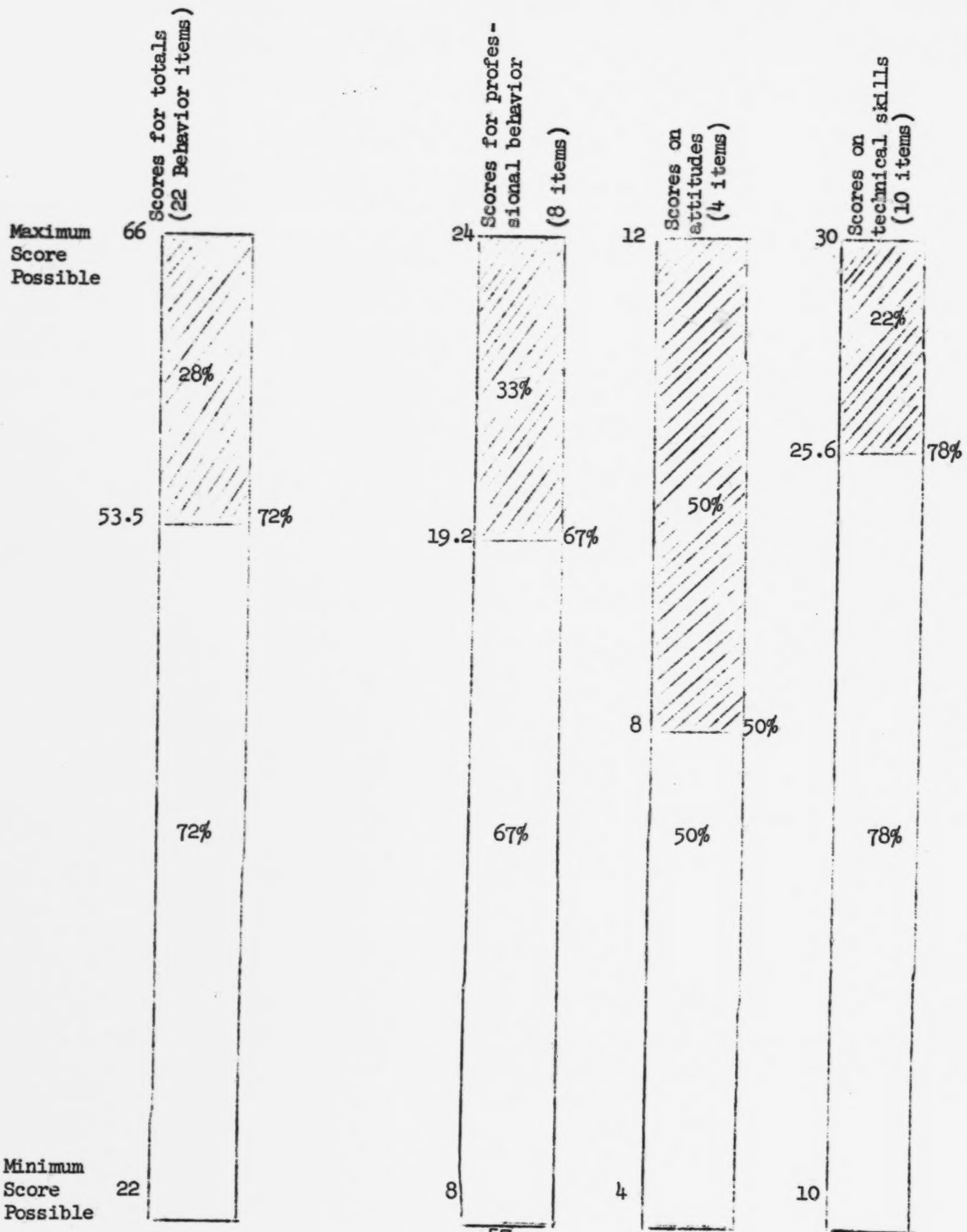


Table 5

Performance Evaluation of 24 Home Health Aides

Possible Range and Actual Range of Scores Obtained
for
Groups and Totals of Behavior Items

	Range of Scores Possible	Actual Range of Scores
Professional Behavior	8 - 24	19.2 - 24
Attitudes	4 - 12	8 - 12
Technical Skills	10 - 30	25.6 - 30
Range of Totals	22 - 66	53.5 - 66

The aides as a group scored the highest in technical skills. All of the aides scored above the 78th percentile for this group of items. They were rated higher as a whole in performing the nursing skills required by the job. This finding tended to agree with the conclusions reached by the instructors during their training class -- that teaching the nursing techniques and skills of caring for patients was the easiest part of the course. This part of the training was satisfactorily accomplished during the program.

Scores on attitude items as a group were the lowest. Individual scores ranged from the top down to as low as the 50th percentile point for the group. Only six of the students received the maximum group score in this area. On the positive side, the results show that the aides scored very high on the single quality of being friendly, warm and pleasant. All of the 24 aides were given top ratings on this item. In the classroom and in the nursing homes, the students were warm, pleasant and friendly and this apparently carried over into the home situations.

On the negative side, the data show that the weakest areas of this group are the aides' inability to accept annoyances and peculiarities of patients, not listening in an understanding way and their not accepting and benefiting from suggestions and criticism. These data are also supported by the results of some of the group sessions during training and the instructor's final evaluations of the students. During training, some had difficulty in accepting a patient's annoying ways and they needed support from the instructors in this area. One of the weakest areas was in accepting criticism. Often when an instructor commented about the need for individual improvement, they personally interpreted it as failure. They tended to equate constructive criticism with failure and usually insisted that they were right. In the final evaluation with the students, the instructors discussed their need for improvement in this area. The students seemed to accept this at the time but the results of this follow-up evaluation definitely indicate a need for further in-service education in this area and a strengthening of the training program in the areas of communication skills and interpersonal relationships.

It is relatively easy to teach a student how to give a patient a bath in bed, but much more difficult to teach the student how to respond in a helpful way to an angry, critical patient. We tried to develop more positive and helpful attitudes through group discussions, role playing and using hypothetical situations but this evaluation indicates that we should have concentrated much more on this aspect of training.

The aides range of scores on the professional behavior items were in between the other two item groups. These scores all fell above the 67th percentile. These results were generally satisfactory although some improvement is indicated. On individual items, the aides were rated higher on grooming and in keeping information confidential. In the classroom the students dressed in good taste and appeared well groomed. No problems were encountered with keeping information confidential. In fact, when the subject of confidentially was discussed in class, the students had strong feelings in favor of keeping personal information private. Many of the students were on or had been on welfare and had personally experienced being in the client role of revealing information to a public agency to obtain service. The instructors, therefore, built on these feelings to reinforce the importance of discussing the patient only with the nurse-supervisor.

The ratings indicated that most of the students had no serious problems with being absent or tardy. Many of the students initially had never worked for a public agency where they were expected to come to work and leave on time. As part of their training in developing good work habits, the instructors insisted they come to class on time and demanded an explanation for tardiness or absence. It appeared that these work habits were developed to a satisfactory level.

Keeping records was an item which showed a wide range of competence. Some of the nurse evaluators commented that some aides reported observations verbally but few kept usable notes. If the aide reported her observations but did not keep notes, she was rated toward the middle of the scale. These results are not surprising when viewed along with the low levels of basic education for many of the aides. For the majority of aides, their verbal skills are better than their writing skills and this indicates the importance of having an effective and continuing program of basic education.

We were not able to obtain a performance evaluation on the rest of the students. These results show the outcomes of only 24 of the total 83 students graduated. This is a sample of approximately one-third the total group.

There is nothing to indicate, however, that this sample is not representative of the total group. The composition of the classes was generally the same and the performance of the students as observed by the training staff was about the same as for those who were evaluated.

4. Results of Basic Education Classes

Two basic education classes were conducted for the two home health aide courses for three hours per day for 11 weeks. One hour each was spent on reading, word attach skills (syllabication and phonics) and mathematics. The sanitation aide class was the same except it was one week shorter.

The results of these three basic education classes are shown in Tables 6 & 7. These data show the number of students in each class, their age range, the number of hours spent in class, the ranges of initial reading and mathematics grade levels and the increases in mathematics grade levels.

Table 6

Reading Grade Levels of Three Basic Education Classes

1 Type of Class	2 No. of Students	3 Age Range of Students	4 Total Hrs. in Basic Education Class	5 Initial Reading Grade Level	6
				Range	Average
Home Health Aide Training Class 1 (1 Group)	18	45-62	165	3.8-7.6	5.8
Home Health Aide Training Class 2 (2 Groups)	35	35-59	165	3.7-11.3	6.5
Sanitation Aide Training Class (1 Group)	12	23-55	150	4.4-15.5	7.5

In Table 6 the initial reading grade levels can be seen in columns 5 and 6. These were measured by the Wide Range Achievement Test (WRAT) and the range of scores is shown in column 5. Column 6 shows the average initial reading grade level for the three classes to be 5.8, 6.5 and 7.5 respectively. The WRAT is not an extremely accurate test but is quick to administer and is adequate for use in screening and assessment. Because it is not precise it is not suitable to measure reading improvement and therefore we do not have adequate data to show the degree of improvement in reading.

Comprehensive tests that give a valid measurement of reading skills tend to frighten many students if given before they have gained a feeling of security in the program. A counsellor gave comprehensive reading tests to the first group of students during the eighth and ninth week of class and some of the students were still excessively nervous and disturbed over the test. It was difficult to allay the fears of even the better students that the results would not brand them for life.

Table 7 shows changes in mathematics scores. Arithmetic progress seemed easier to measure. The Wide Range Arithmetic Achievement Test (WRAAT) was given to Class 1 during the first week of class. This frightened a number of students and caused a few persons to get help from their neighbors. It was determined later than certain individuals had significantly lower skills than the tests indicated. This may have accounted for the fact that three scored a slight negative improvement at the end.

By the end of the eleventh week the class agreed to retake the test to find out how much they had improved in mathematics. As can be seen in column 10 Table 7 the average grade level increase was 1.6. The range of change was from -.2 to 4.6. Increased knowledge and skills, less nervousness and more experience in taking tests were factors which led to the significant increases.

Table 7

Changes in Mathematics Grade Levels as a Result of Three Basic Education Classes

1	2	3	4	5	6	7	8	9	10
Type of Class	No. of Students	Age Range of Students	Class hours in Math	Initial Math Grade Level		Final Math Grade Level		Change in Math Grade Level	
				Range	Av.	Range	Av.	Range	Av. Increase
Home Health Aide Training Class 2 (1 Group)	18	45-62	55	3.3-6.4	4.5	3.9-9.9	6.1	-0.2 to 4.6	+1.6
Home Health Aide Training Class 2 (2 Groups)	35	35-59	55	3.1-7.7	4.8	3.5-11.8	6.4	0.0 to 5.9	+1.6
Sanitation Aide Training Class (1 Group)	12	23-55	50	3.5-8.1	5.2	4.5-13.3	8.7	.5 to 7.5	+3.5

For the second class the WRAAT tests were administered during the first and eleventh weeks of the course. In the initial testing, the 35 students scored an average of 4.8 grade levels. On re-evaluation the group averaged a 6.4 level, giving the same 1.6 average grade level increase as the first class. Two very slow learners showed no improvement. Four students improved from 0.4 to 1.0 grade levels; 16 increased from 1.1 to 2.0 grades; 10 increased from 2.1 to 3.3 grandes and three students increased 4.1, 4.9 and 5.9 grades respectively.

Although the average grade level increase was the same for both classes the performance of the second group seemed to be better. This was probably due to several factors. First, the instructor did all of the initial interviewing, testing and screening and was thus able to meet, assess and establish a personal relationship with each student by the end of the second or third day of class.

Secondly, the assistance of a teaching aide in the second basic education classes was extremely helpful. The aide graded almost all the papers, freeing the instructor to develop more instructional materials which were integrated with the HHA training program. The students were thus given more individualized help and faster and more complete feedback on their progress. It seemed the students felt more secure and learned faster when they had tangible evidence of their own progress each day.

The increase in math skills for the men in the sanitation training program was much more dramatic. Their average grade level increase was 3.5 and they ranged from .5 to as high as 7.5. The greater progress in this group was due to several factors; a smaller class, a younger age group, a higher average education level and more teaching experience of the basic education instructor. The instructor was the same person throughout, however, as the classes progressed he developed better teaching methods and materials for the trainees.

These data show rather significant increases in math grade levels in only 55 and 50 hours of instruction. Mathematics progress is the easiest to measure and appeared to show the greatest increase of all the basic education taught. An average increase of 1.6 grade levels from 55 hours of classroom instruction taught to this population group in this manner is a rather surprising outcome if it is compared to the traditional system of elementary education where a student spends approximately three times that amount of classroom hours for each grade in school.

The area where we had the least success was in writing improvement. Our experience showed this area to be difficult, embarrassing and time consuming for the students. Since we believed that this was the least important for vocational training we did not spend a great deal of time on writing. It does indicate an important need for continuing education in this area.

SPECIAL TRAINING AND USE OF HEALTH AIDES

One of the objectives of the project was to experiment with training other kinds of health aides. At the end of the first home health aide training session 17 of the 38 students in the class were selected for special training.

1. General Public Health Training

These students were picked because of their interest in learning about and working in other health department programs and their demonstrated ability in the class. This special training group fit in well with the general health department program since during the past few years the department had begun to use health aides in some of its programs. Some of the ongoing programs in which health aides had been used to extend existing manpower were immunization, tuberculosis, venereal disease, dental health, infant and pre-school health, school health, family planning, communicable disease and sanitation. The aides the health department hired had not been given any extensive training but were trained on a one to one basis by the public health nurses or other staff of the districts.

With the cooperation of the entire health department staff a special training program was planned. The first session began with an overview of health department programs. This was followed by sessions on communicable diseases and information about the venereal disease control and the immunization program carried out by the health department. After the students learned about immunization they were given immunization cards and made home visits to families in the community to carry out what they had learned in class.

The Dental Health Bureau planned a week's session on dental health. This included an overview of the Dental Care Project, problems involved in getting families to the dentist, growth and development of teeth, and care of mouth and teeth.

The Bureau of Public Health Nursing planned the sessions on maternal and child health, infant care and family planning. Each student spent a day with a public health nurse to observe dental problems and maternal and child health problems in the community.

Several field trips were planned. The students visited the service centers and learned about the poverty health programs carried on in the community. They also toured the health department library.

The public health nurse in charge of the Oakland Public Schools Head Start Program explained the rationale and the scope of the Head Start Program in Oakland. Child care centers administered by the Oakland Public Schools were explained by the public health nurse in charge of these centers. The Center on Alcoholism gave a three hour discussion on the games alcoholics play and the services the alcohol clinic offers the people in the community. Alameda County Welfare Department participated in training the students and sent their person in charge of the training program for beginning social workers to speak to the students about welfare programs.

The training officer for Alameda County gave a morning session on defensive driving. We felt this was important as many of the students would be driving on the job and good driving habits were important. The last sessions were conducted by the sanitarian on the project. He discussed the sanitation problems the students should report to the Bureau of Sanitation for investigation and correction.

The latter part of August and through the month of September twelve of the students worked on follow-up of children attending the Oakland Public Schools Head Start Program. The public health nurses employed by the Oakland Board of Education had been unable to complete the follow-up on the head start children. The follow-up cards were sent to the health department and the crash program was assigned to the students. A public health nurse from the Children and Youth Project and two senior aides from the Home Health Aide Training Project supervised the students.

These twelve students had an opportunity to use the information learned in the special training sessions to do follow-up on these children. Five of the students who had been in the special training sessions now had full-time jobs in other health department programs.

A summary evaluation of their part of the Oakland Head Start Program showed that 367 children were contacted from the 11 schools assigned to the Alameda County Health Department by Oakland Public Schools and of these 19 medical appointments and 64 dental appointments were made by the public health nurses and aides combined. The students found out that 106 medical and dental appointments made by Oakland Public Schools nurses were kept. In addition, immunizations and tuberculin skin test information was obtained on 62 students and 47 referrals were made where additional immunizations and skin tests were needed.

The students had problems keeping records and had to return to the families to get additional information but they proved that health aides can successfully participate in these programs. Some of the students that were trained in this manner are now working or are scheduled for work in various health department programs.

2. Special Home Health Aide Training

   In addition to this public health training of health aides the project held a special accelerated class for 13 home health aides who were working in the Home Health Care Program but had not been able to get a state certificate. They had enough work experience but lacked some of the knowledge and formal skills training to become certified. Special state funds were obtained for stipends and one instructor from the training project taught the course. Thirteen students graduated from this course.

3. Training in Sanitation and Venereal Disease Control

In September a class of 15 men was begun to train them to work in sanitation and venereal disease control programs of the department. This class was substituted for the third home health aide class that was cancelled. The procedures for developing and conducting the class for men were similar to those used for the other classes. Details about the methods used and the outcomes are included in Attachment 13, Report on the Training of 15 Men in Sanitation and Venereal Disease Control.

EMPLOYMENT OF HOME HEALTH AIDES

The Alameda County Health Department since June 17, 1966 has been a state certified Home Health Care Agency. Prior to June 17, 1966, the department had conditional certification as a home health agency. During this period home health aides were employed on an hourly basis as needed at the following rates of pay:

$2.00 an hour from March 1966 through June 30, 1966
$2.10 an hour from July 1, 1966 through February 28, 1967
$2.25 an hour from March 1, 1967 to June 30, 1967
$2.35 an hour from July 1, 1967 to the present time (December 31, 1967)

In addition to home health aides, other types of health aides have been employed in the department by special project monies. The use of health aides started in October 1965 when poverty program money first became available for special health programs in poverty target areas. Employment of health aides in special projects has expanded and now includes the following areas: home health care, concentrated employment project, dental care, general health promotion, family planning, sanitation, immunization and multiphasic screening.

As of December 31, 1967, the Alameda County Health Department had a total of 137 health services aides on the staff. Of these, sixty-five were working full-time in the various programs mentioned above. The remaining seventy-two were working half time or on an hourly basis in the programs enumerated above.

Since July 1, 1967 the health department has been able to create four new job classifications as Health Services Aides within the County Civil Service System. These four positions are Health Services Aide Trainee, Health Services Aide I, Health Services Aide II and Senior Health Services Aide. This has made it possible to employ health aides with full-time provisional civil service appointments. This not only guarantees more job security for the aides, but enables them to receive all the regular benefits of any other County employees. The descriptions and salary ranges of these four civil service positions are shown in Attachment 14.

59 of the 83 home health aides that graduated from the project have already been employed as of December 31, 1967. They are working in various capacities as follows: 24 of the graduates have provisional civil service appointments as Health Services Aide I. 8 of these 24 are working as general health services aides. They are under the supervision of a public health nurse and are carrying out the regular services of the health department. 16 of these full-time aides are working in the home health care program carrying a full caseload of at least 32 to 35 hours a week. This does not include travel time.

24 of the graduates have been assigned part-time work as home health aides in the Home Health Care Program. They are employed on an hourly basis and thus are not eligible for the regular benefits of civil service appointments. However, these home health aides are working, on the average, of 17.7 hours per week.

3 of the graduates are working for a home health agency in San Francisco and it is our understanding that they are working full time with all of the agency benefits of full-time employment.

3 of the graduates are working full time as general health services aides in the Concentrated Employment Project under the supervision of a public health nurse. They administer health screening inventories, participate in review of the inventories for possible medical problems and visit youths who have health problems and refer them for medical care.

2 of the graduates are working in the Dental Care Project and, under the supervision of a public health nurse, are encouraging families to get their children under dental care. They also assist the families to make and keep appointments with the family's dentist.

1 of the graduates is working on the Poverty Health Program as a sanitation aide. Under the supervision of a registered sanitarian, she is working in environmental health programs such as, backyard sanitation, garbage control, rubbish clean-up, insect problems, rodent problems, and the rabies vaccination program.

1 of the graduates is working half time as a family planning aide in the Fruitvale Family Planning Project. This project is being sponsored jointly by the Planned Parenthood Association of Alameda County and the Alameda County Health Department.

Another graduate is working full time in the health department's mobile multiphasic clinic. She is bi-lingual and has learned to do most of the screening tests except taking blood samples and doing electrocardiograms.

As of the end of the Project on December 31, 14 of the graduates were undergoing special on-the-job training and receiving stipend funds. They have been carrying out an immunization survey. This survey is being conducted to evaluate the intensive educational program the health department has been carrying out for the past three and one-half years. As of December 31, 1967 no jobs had been found for them in the community.

These 14 students present a problem. They have been extensively trained and efforts are being made to find jobs for most of them within the health department. There is at this time a Children & Youth Project which is funded for six full-time health aides. Five of the students on traineeship funds live in the project area and will probably be employed in this project shortly after the first of the year. The other nine graduates will be transferred to the home health care budget and will probably work part time.

The remaining ten graduates are accounted for as follows:

2 married and no longer need to work

1 has a job cooking in a fraternity house

1 is working full time for an 85-year old man

2 returned to school

3 are off ill temporarily

1 is unemployed

Eventually the Home Health Care program will have forty-one (41) hourly employees who have graduated from our Home Health Aide Training Project. There are, however, 67 hourly employees attached to the Home Health Care Program. 26 of these were trained in other programs in the community. The Home Health Care Program cannot support 67 part-time home health aides. If the Home Health Care Program expanded to 600 home health care cases, then we could offer these graduates of our program at least one-half time employment. However, the average caseload of the program ranges between 362 and 400 cases. The highest case count we have had to date is 412.

The number of jobs for home health aides is directly related to the request by physicians for home care service to patients. Efforts are being made by the health department to educate the physicians in the area as to the availability of home care services for their patients. In October, before the supervising nurses were released from the project, they visited over three hundred internists and general practitioners to inform them of the services of the Home Care Program. Brochures have been mailed out to most potential referral sources. It was hoped that this personal contact would raise the number of new referrals to an appreciable degree. The results so far have been disappointing as the number of new referrals has not increased significantly. The health department feels responsible to provide full-time employment to its graduates, but so far we have not been able to completely fulfill this commitment.

1. Size and Duration of Project

The budget of the project contained ample funds for staff and resources to achieve the primary objective - to train 120 home health aides. Difficulties were encountered, however, in demonstrating and experimenting with new and different techniques of recruitment, selection and training. The main problem in this respect was the pressure of time.

Since the project had a one year limit and the first month went by before most of the staff were employed there remained only 11 months within which to operate. The pressure in the beginning to get started with recruitment and training activities left inadequate time for orienting and training the staff, planning the various stages of operation and developing in advance adequate criteria and measures for evaluation and follow up action.

More advance time was needed to develop lesson plans and audio-visual materials for the first class. More time should also have been allowed between training courses to evaluate the results and make revisions for the next course. The staff and facilities were adequate to conduct 3 consecutive sessions of 11 weeks each for 40 persons per class but they were not adequate to experiment with smaller size classes and to try out and compare different training methods.

Another situation that made it difficult to be flexible and to make revisions as the project went on was the large amount of staff time that was spent on managing the project - time that was necessary to supervise, manage and work out personnel problems with 20-30 full and part-time staff members, time spent in scheduling trainees for field visits to nursing homes and home care cases and other time-consuming activities. Every change that was made in the program meant more time in rescheduling, etc., and this did not make it easy to make changes and try out as many different approaches as we would have liked.

More time was also needed at the end of training to evaluate all of the trainees' performance after they had become employed. Time permitted an adeuqate follow-up evaluation of the first class but not for subsequent classes.

Considering these difficulties, the project would have been better able to test different techniques and approaches to recruitment, selection, training and evaluation if it could have continued for two years instead of one.

2. Administration Through a Local Health Department

There were both advantages and disadvantages of conducting a demonstration training project of this nature within a relatively large local health department.

Positive Factors

There were at least several assets which an agency such as the Alameda County Health Department contributed toward the operation of the project.

a) The health department, being a large agency and employing some 282 professional staff, provided an available supply of personnel. Many of the staff were persons who had many years of experience in various disciplines of public health including nurses, nutritionists and other health specialists. Some of these persons were selected for the project staff and others provided valuable assistance in the planning stages, in the field training phases, in special training programs for the aides and in the evaluation stages. These staff persons with their understanding of the community and their knowledge of how to operate within the Health Department structure were a very valuable asset to the project.

b) The Alameda County Health Department conducts a wide variety of health programs for the large and varied urban and rural population it serves. This provided an excellent resource for field training experiences for the students. We were thus able to provide an orientation to the entire spectrum of health services - from preventive medicine and community health to personal health care.

c) Conducting the project through the health department resulted in a large number of department staff being willing to accept students for special training assignments and other help. The training staff was thus able to get good consultation from the regular department staff and to obtain better feedback on the results of on-the-job training.

d) Since the Health Department is a certified Home Health Care Agency it was able to provide ample on-the-job training experiences and directly employ the students once they became certified. One of the chief advantages of this situation was the control which the department had (and likewise the project staff had) over the supervision of the home health aides who were employed and the obvious advantage this was in conducting a follow-up on-the-job evaluation of the aides.

e) Another advantage which a large county agency provided was an established administrative structure with a system for ordering equipment and supplies. The county system also provided other institutions such as hospitals and clinics from which we could borrow training equipment and supplies.

Negative Factors

On the negative side, there were several difficulties inherent in a large governmental agency which hindered the operation of the project.

a) One of the most limiting factors were some of the rigid policies and procedures of the county system. One of these was the policy of once-a-month pay which made it impossible for us to pay the trainees any oftener than once per month. Many of the financial problems of our student were caused by this policy. Sometimes the formal procedures required in ordering and obtaining supplies prevented us from getting some items as quickly as we needed them.

b) The County Civil Service System caused problems in our efforts to obtain some specialized staff who had the training and experience which we desired. Salary levels are fixed by Civil Service and even though we had project funds available, we were not able to offer salaries above the County Civil Service standards.

c) Some difficulties were experienced in scheduling the rooms which were used for training the students. When large health department meetings were held, it was necessary to cancel some of the training sessions in order to accommodate the health department staff. Since there were no permanent meeting room facilities in the department for training our students and we had to schedule the regular meeting room spaces for our classes, it was difficult to change class schedules to accommodate changing situations in the training project.

d) Health department policies made it impossible or difficult to carry out several experimental elements of the project such as testing different approaches to selection and training.

ECONOMIC COSTS AND BENEFITS

A final evaluation report would not be complete without some kind of analysis of the economic costs and benefits of the program. An accurate analysis of such costs and benefits is difficult to determine but it is possible to estimate closely the costs for training each student and to estimate the more obvious economic benefits to society when a person out of work or on welfare becomes fully employed as a health aide.

1. Cost of Training - The cost of training and certifying a home health aide student is estimated using the costs of project staff salaries, stipends, medical care services, and overhead for 6 months. Eighty-three students were graduated from two training sessions of eleven weeks each. The average cost per student is figured on the basis of the 83 students who were graduated from the two eleven-week courses. The 6 months cost figure seems reasonable since the remaining time of the project was spent on general planning, evaluation, development of educational materials and other activities not directly related to the training of the 83 students. The training costs and the resultant average per graduated student are shown in Table 8.

Table 8

Average Cost of Training a Home Health Aide Student

	Monthly Salary	Salary for 6 Months	
Teaching Staff			
1 Supv. PHN	$ 1,074	$ 6,444	
2 Supv. PHN	2,046	12,276	
1 Staff Nurse	693	4,158	
3 Senior Aides	1,392	8,352	
1 Basic Education Instructor (1/2 time)	720*	4,320*	
1 Teacher Aide (1/2 time)	153	918	
1 Social Worker (1/2 time)	441	2,646	
	$ 6,519		$39,114
*Paid by the Oakland Adult Education Department			
Other Staff:			
1 Project Director	$ 1,371	$ 8,226	
1 Adm. Ass't.	841	5,046	
1 Chief PHN	1,184	7,104	
1 P.H. Representative	841	5,046	
4 Secretarial & Clerical	1,880	11,280	
	$ 6,117		$36,702
Educational stipends for 83 students @$45 per week for 11 weeks			41,085
Physical examinations for 83 students @ an average of $14 each			1,162
Overhead (includes supplies, mileage, etc.) estimated at 20% of all other costs			23,613
Total			$141,676
Average estimated cost of training each student			$ 1,707

Table 8 shows that the average cost of training each home health aide in the project was $1,707. This covers all direct training costs for both basic education and the home health aide training. These costs also include those for both the recruitment and training periods of the two classes of students. The actual training staff costs are a bit high, since two of the nurse instructors were not employed until almost the second class began. As a result, there is 12 weeks (approximately $12,000 worth) of salary time which is figured in the cost but was not actually spent. It is included in the cost estimate, since it is probably a more realistic figure. Had the two nurse instructors been available for the first class, there would have been fewer students per instructor, which would have allowed more individual attention for each trainee.

2. Economic Benefits

Direct tax returns from employment

The economic benefits to the community of employing home health aides can also be estimated. Assuming that the 83 graduates were employed fulltime, that each supported a family of four and that their fulltime wages (at rates existing at time of employment) comprised their total annual income, the direct tax returns to the federal and state government can be computed. These figures are shown in Table 9.

Table 9

Economic Benefits from Employed Graduates

I.		Income Per Individual	Income for Total Group (83 persons)	
Potential FulltimeEarnings:	per hour	$ 2.35	$ 195.00	
	per week	94.00	7,802.00	
	per month	376.00	31,208.00	
	per year	4,512.00	374,496.00	$374,496.00
II.		Per Family	Total Group	
Anticipated Federal Income Taxes per Year for Family of Four		$ 224.00	$ 18,592.00	$ 18,592.00
III.		Per Family	Total Group	
Estimated Annual California Sales Tax @ 5% (based on average yearly expenses for family of four at above income)		$ 226.00	$ 18,725.00	$ 18,725.00

- -

Total Annual Wages Earned for the Group		$374,496.00
Total Annual Return of Tax Dollars to the Public (Items II plus III)		$ 37,317.00
Annual Return of Investment for the Total Group Trained	$\frac{\$37{,}317\text{ (tax dollars returned)}}{\$141{,}676\text{ (cost of training)}} =$	26%

The figures in Table 9 show that the estimated total annual return of tax dollars to the public from 83 students becoming fully employed would be $37,317. The annual return on the money invested in training these persons ($141,676) is approximately 26%. Over a four-year period, the total amount of money invested in training the group would be returned to the taxpayers in the form of federal income and state sales taxes.

Savings in Welfare Costs

Twenty-seven of the 83 trainees were welfare clients and most of these were receiving aid to Families with Dependent Children (AFDC). The welfare status of the group varied - some were on General Assistance and received very little aid, while others on AFDC received the maximum aid allowable. For simplicity sake, to estimate the savings in welfare costs that are possible when persons in this situation are trained and employed, the cost figures for an average family of four will be used. This would be a mother with three dependent children living in Alameda County, California. The maximum monthly AFDC reimbursement allowed by the State and Federal regulations for this family of four would be $221.00.

The annual AFDC cost per family would be $2,652.

The average cost of training each home health aide was $1,707.

By comparing these figures together, it shows that the cost of training an unemployed female head of a household as a certified home health aide is approximately two-thirds the cost of keeping her and her three children on welfare for one year.

Let us assume that such training enables this welfare client to become fully employed as a home health aide, thereby eliminating the tax dollars formerly required to support her on AFDC. The resultant savings in monies to the taxpayers can therefore be estimated as follows:

1. The annual return on money invested in training when an AFDC client (family of 4) becomes employed is 182%. This is determined as follows:

   $$\frac{\$450 \text{ (ann. tax dollars returned)} + \$2,652 \text{ (ann. AFDC savings)}}{\$1,707 \text{ (average cost of training)}} = 182\%$$

   This figure of 182% annual investment return is vastly greater and more significant for a welfare client than for the group of students as a whole.

2. The estimated net savings to the taxpayers for this group of 27 welfare students for the first year would be $42,585.

   $71,604 (total ann. cost of AFDC) - $29,019 (total cost of training) = $42,585

   This assumes that the total group of 27 trainees were on the same AFDC status (family of 4) and that all were fully employed after becoming certified as home health aides.

Other Benefits

In addition to the above monetary benefits, the 83 persons will have a total annual take-home pay of approximately $337,169 which will contribute to their own and their family's level of health, education, productivity and other aspirations. The major portion of this money will be spent in the community for food, housing, clothing, recreation, medical care, education, and a host of other goods and services.

The above benefits from training and employment have all been expressed in terms of monetary values. But the personal benefits that accrue when an individual can obtain a meaningful job, become self-sustaining and contribute to society in a productive way cannot be assessed in terms of dollar values. People who psychologically and spiritually become more fully functioning human beings through education and employment are of inestimable value to the society in which they live.

RECOMMENDATIONS FOR FUTURE PROGRAMS

The last section of this report contains recommendations for future programs. These recommendations grew out of the experiences of the project and are ones which the staff felt were important to highlight and which should be considered in future training programs of this kind. The recommendations are listed under the subject heading to which they apply.

Employment

1. The highest priority recommendation is that enough jobs be available for trainees when they graduate from the course. People should not be trained for jobs that do not exist. The decreasing number of home health aide jobs toward the end of the project had a demoralizing effect upon the students in training.

Recruitment and Selection

1. Criteria for admitting men may have to be different (i.e. broadened or relaxed) than for women in order to attract men into jobs as home health aides.
2. Different recruitment methods should be used for men than for women in order to find men who are interested and available.
3. Members of interview and selection teams should have special training in sensitivity or encounter groups, interviewing techniques and observation methods. A social worker and a member of the training staff should be part of any team interviewing and selecting applicants.
4. Different methods of selection should be tested for effectiveness in selecting individuals for the qualities desired. It is believed there is value in the group interview method to stimulate interaction, to get individuals to reveal themselves more openly and to determine the applicant's real interest in the job. The use of community or target area screening boards should also be investigated.

5. The selection procedure should allow ample time for careful consideration and screening of all applicants.
6. Applicants with police and arrest records should be reviewed on an individual basis with full consideration given to the person's interest and potential abilities and not rejected just because a past record exists. The validity of the often stated belief that persons with arrest records are unsound risks to the employing agency has not yet been proved and further evidence is needed to determine if this risk is in fact a reality and if so to what extent.

Technical Training

1. Training classes should be small to provide sufficient individual attention for the type of trainees recruited into this project. The recommended ratio would be one instructor per ten students.
2. The use of health aides to assist the teaching staff is highly recommended and this can help reduce the instructor to student ratio.
3. Training staff should be appointed well enough in advance to adequately plan and prepare curriculum plans and materials.
4. Adequate orientation and training of the teaching staff in effective educational methods for low income groups is essential for persons without such previous experience and training.
5. Ample time in the training program should be devoted to developing appropriate attitudes and skills for supervision. Trainees should be able to accept and help promote a productive relationship with their supervisor.
6. Opportunities should be provided to enable individual students and the instructor to know each other better. It would have been helpful if

instructors had more time for counselling and could have visited students in their home to get a better understanding of each person and their family situation. Smaller classes would enable instructors to get to know students better and provide more time for individual help.

7. Adequate time should be allowed for on-the-job training and close supervision provided during this phase. Concurrently with on-the-job training frequent small group sessions should be planned so students can discuss and work out problems which arise with their patients or supervisor.
8. Regular study periods should be built into the training program and staff and other resources made available to the students during these periods.
9. Training staff should have time to meet at least once a week to discuss problems that arise and work out solutions to them.
10. Opportunities should be provided by the employing agency for continued in-service training and education of health aides. Workshops, conferences, seminars and other training sessions should be planned as needed to provide professional stimulation and advancement and education for new health problems, programs and responsibilities. The agency should provide time for staff to participate in such activities related to professional development.
11. Orientation and training should be given to agency staff who will be supervising health aide personnel. Particular attention should be focused on the nature and techniques of supervision and the understanding of the health aide as a person, his role and function in the agency.

Basic Education

1. Basic education should be an integral part of home health aide or other health aide training for students with educational backgrounds from at least below the 8th grade levels. Such basic education should be functional in nature, integrated with the technical training and aimed at the job to be performed.

2. Some form of testing or screening should be done prior to the beginning of training to determine the requirements of each person for basic education.

3. Opportunities should be provided for those trainees who need it to continue in basic education over an extended period of time. Assistance should be provided for such education to continue after training either on agency time or on the aides own time.

Individual Problems of Students

1. It is essential that stipends be paid to poor people for training. The amount of stipend should be comparable to the job wage and adequate to maintain the individual and his family during the period of training. Without financial assistance most persons are unable to undergo training.

2. Trainees should be paid at least twice per month. Once a month pay creates too many financial hardships on students.

3. A well defined policy should be developed by the staff and explained to the students. Such policies should include expectations for attendance and absences and responsibilities for personal conduct in class. Such policies snould be enforced firmly but enough flexibility allowed so that students who have personal or family problems can be helped through counselling and other ways.

4. Adequate professional staff and time should be provided to assist individual students with their personal problems. Both individual and group counselling is recommended. Students will thereby have the benefit of a one to one relationship with a professional nurse or social worker counsellor plus the encounter group experience where they can work out their problems with their peers.

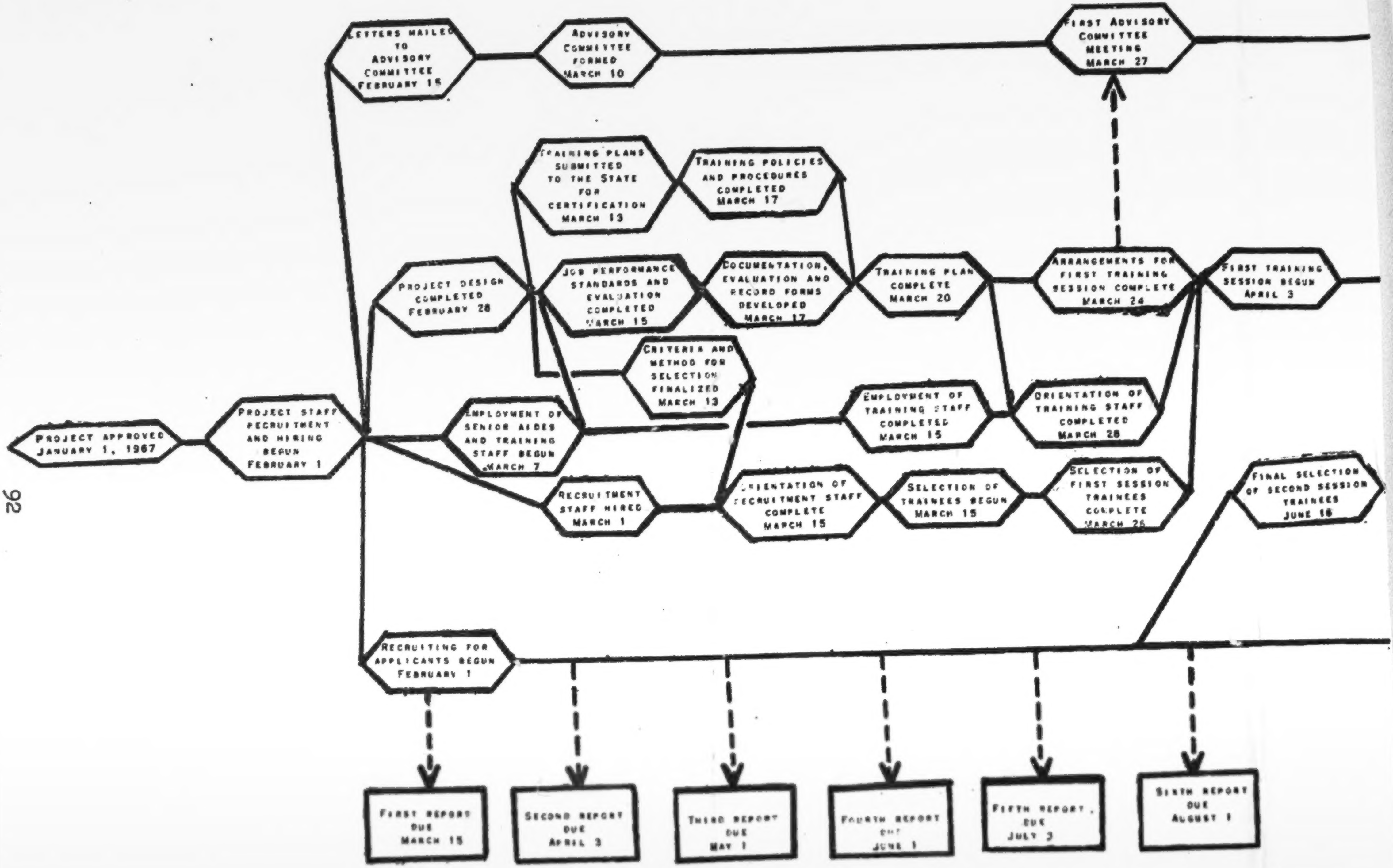
5. Special assistance or supportive services may be necessary to aid students who have problems with child care, transportation and care of sick relatives.

6. A preliminary screening procedure should be set up to detect serious physical or emotional health problems and provide corrective medical or referral services. Medical treatment and corrective services should be arranged for persons who have health problems that are not serious enough to interfere with the job. Persons having health problems too severe for training and employment should be referred to agencies that can provide adequate health care.

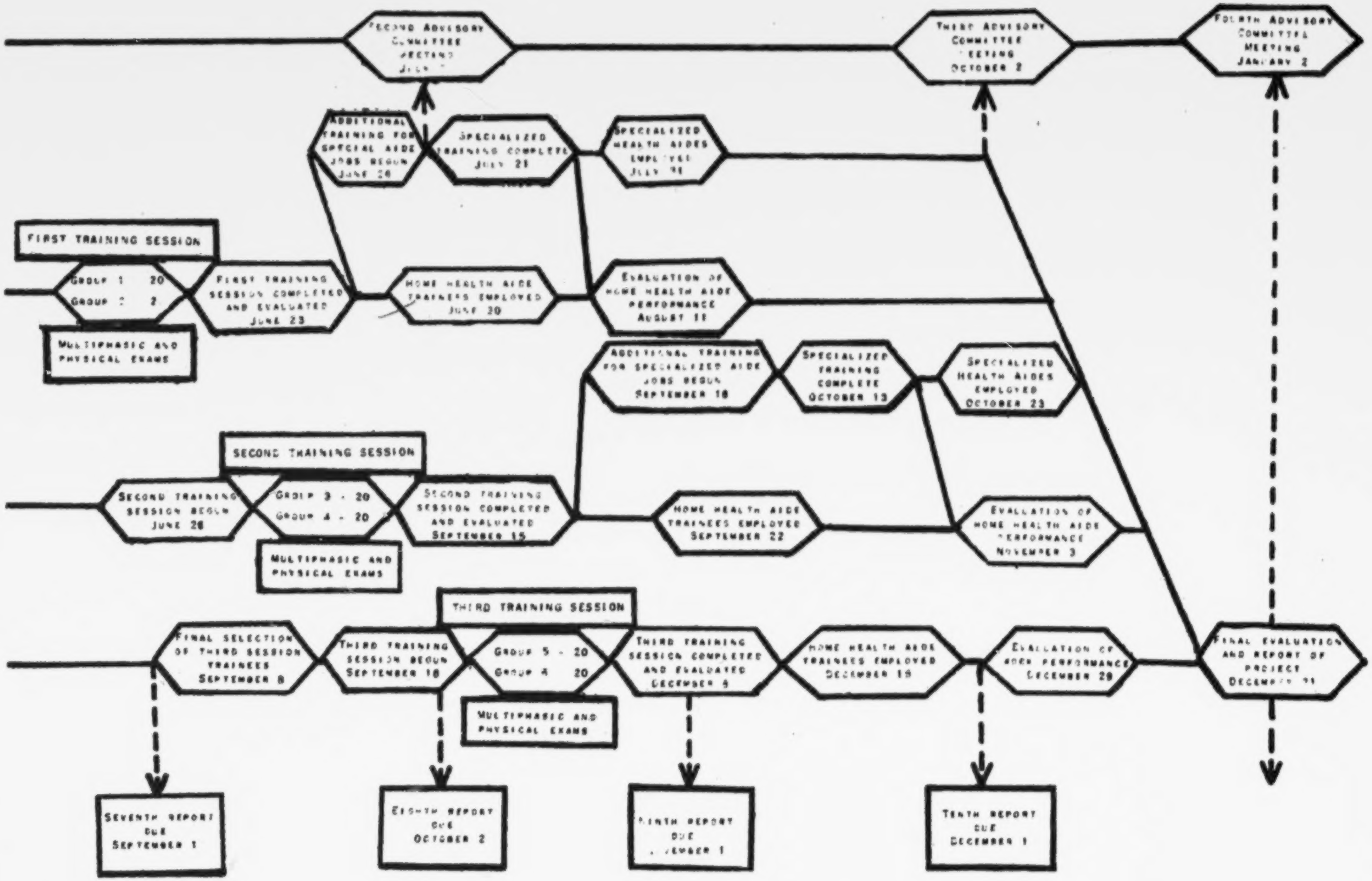
ATTACHMENTS

HOME HEALTH AIDE TRAINING PROJECT

ACHD OAKLAND

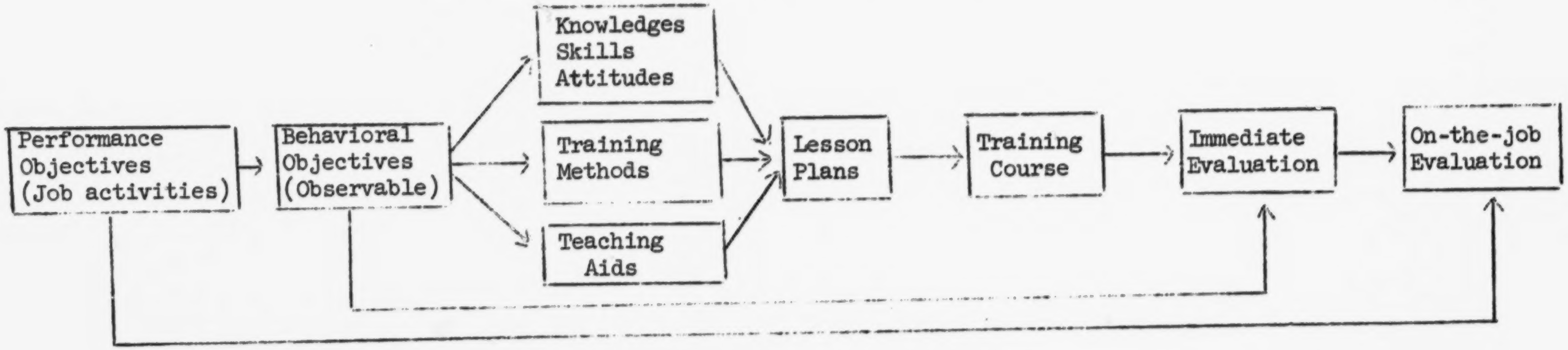

PROJECT APPROVED JANUARY 1, 1967
PROJECT STAFF RECRUITMENT AND HIRING BEGUN FEBRUARY 1
LETTERS MAILED TO ADVISORY COMMITTEE FEBRUARY 15
ADVISORY COMMITTEE FORMED MARCH 10
FIRST ADVISORY COMMITTEE MEETING MARCH 27
TRAINING PLANS SUBMITTED TO THE STATE FOR CERTIFICATION MARCH 13
TRAINING POLICIES AND PROCEDURES COMPLETED MARCH 17
PROJECT DESIGN COMPLETED FEBRUARY 28
JOB PERFORMANCE STANDARDS AND EVALUATION COMPLETED MARCH 15
DOCUMENTATION, EVALUATION AND RECORD FORMS DEVELOPED MARCH 17
TRAINING PLAN COMPLETE MARCH 20
ARRANGEMENTS FOR FIRST TRAINING SESSION COMPLETE MARCH 24
FIRST TRAINING SESSION BEGUN APRIL 3
CRITERIA AND METHOD FOR SELECTION FINALIZED MARCH 13
EMPLOYMENT OF SENIOR AIDES AND TRAINING STAFF BEGUN MARCH 7
EMPLOYMENT OF TRAINING STAFF COMPLETED MARCH 15
ORIENTATION OF TRAINING STAFF COMPLETED MARCH 28
RECRUITMENT STAFF HIRED MARCH 1
ORIENTATION OF RECRUITMENT STAFF COMPLETE MARCH 15
SELECTION OF TRAINEES BEGUN MARCH 15
SELECTION OF FIRST SESSION TRAINEES COMPLETE MARCH 25
FINAL SELECTION OF SECOND SESSION TRAINEES JUNE 16
RECRUITING FOR APPLICANTS BEGUN FEBRUARY 1
FIRST REPORT DUE MARCH 15
SECOND REPORT DUE APRIL 3
THIRD REPORT DUE MAY 1
FOURTH REPORT DUE JUNE 1
FIFTH REPORT DUE JULY 3
SIXTH REPORT DUE AUGUST 1

ATTACHMENT 1


Second Advisory Committee Meeting July 7
Third Advisory Committee Meeting October 2
Fourth Advisory Committee Meeting January 2
Additional training for special aide jobs begun June 26
Specialized training complete July 21
Specialized health aides employed July 31
First Training Session
Group 1 20
Group 2 20
Multiphasic and physical exams
First training session completed and evaluated June 23
Home health aide trainees employed June 30
Evaluation of home health aide performance August 11
Additional training for specialized aide jobs begun September 18
Specialized training complete October 13
Specialized health aides employed October 23
Second Training Session
Second training session begun June 26
Group 3 - 20
Group 4 - 20
Multiphasic and physical exams
Second training session completed and evaluated September 15
Home health aide trainees employed September 22
Evaluation of home health aide performance November 3
Third Training Session
Final selection of third session trainees September 8
Third training session begun September 18
Group 5 - 20
Group 6 20
Multiphasic and physical exams
Third training session completed and evaluated December 5
Home health aide trainees employed December 15
Evaluation of aide performance December 29
Final evaluation and report of project December 31
Seventh report due September 1
Eighth report due October 2
Ninth report due November 1
Tenth report due December 1

ATTACHMENT 2

DIAGRAM OF THE DEVELOPMENT AND EVALUATION OF THE HOME HEALTH AIDE TRAINING COURSE


Performance Objectives (Job activities)
Behavioral Objectives (Observable)
Knowledges Skills Attitudes
Training Methods
Teaching Aids
Lesson Plans
Training Course
Immediate Evaluation
On-the-job Evaluation

Performance Objectives:	List of those activities required to be performed by the trainee upon completion of course and when employed as a home health aide.
Behavioral Objectives:	List of what the student must be able to do, stated in observable terms, and under what conditions, in order that achievement can be measured.
Knowledges, Skills and Attitudes:	Identification of the knowledges, skills and attitudes required of the student in order that he be able to perform each objective.
Teaching Methods and Teaching Aids:	Determination of the educational experiences and audio-visual materials required to teach the desired knowledges, skills and attitudes.
Lesson Plans:	Development of the course content, teaching methods and materials into lessons which are programmed in terms of unit concepts.
Training Course:	Actual presentation of lessons in a meaningful order.
Immediate Evaluation:	Test of student's achievement at end of course and based upon the behavioral objectives.
On-the-job Evaluation:	Test of student's effectiveness in performing the activities which are expected on the job.

ALAMEDA COUNTY HEALTH DEPARTMENT

HOME HEALTH AIDE TRAINING PROJECT

Duties of a Home Health Aide

General:

Under the supervision of a public health or registered nurse, a home health aide helps sick and disabled persons to overcome illness or to become as self-sufficient as possible. The home health aide gives personal health care to patients as ordered by a physician and provides related housekeeping services in the home.

Specific: A home health aide performs any of the following tasks:

1. Practices professional behavior in the home.
   a. Dresses in a neat and clean manner.
   b. Keeps information confidential.
   c. Follows the health care plan arranged by the nurse.

2. Communicates effectively with the patient and family, the nurse and other members of the health team:
   a. Understands instructions given by the nurse and therapist.
   b. Tells the nurse-supervisor of changes in the patient's condition.
   c. Explains to the patient and family what the HHA will do and why it is important to follow the doctor's orders.
   d. Listens to and understands the patient's and family's beliefs about illness or disability.
   e. Accepts and acknowledges emotional feelings expressed by the patient or family and responds in an understanding way.

3. Encourages the family to accept the responsibility and to care for the patient as much as possible.

4. Assists or performs for patient the following personal care tasks:
   a. Bath in bed.
   b. Bath in tub or shower.
   c. Care of mouth.
   d. Brush teeth or dentures.
   e. Grooming and assisting with make-up.
   f. Back rub.
   g. Shampoo hair.
   h. Care of skin as directed by nurse.
   i. Care of feet, hands and nails.

5. Helps patient to move in and out of bed and chair:
   a. Turn and position patient in bed.
   b. Sit up in bed.
   c. Get in and out of bed.
   d. Get in and out of chair or wheelchair.
   e. Walk about.
   f. Walk up and down stairs.

6. Assists patient to use cane, crutches or wheelchair:
   a. Walk with cane.
   b. Walk with crutches.
   c. Propel wheelchair.

7. Helps patient with prescribed exercises:
   a. Exercise in bed.
   b. Exercise out of bed.

Duties of a home health aide - continued

8. Helps patient to use bedpan or toilet:
   a. Use of bedpan.
   b. Use of urinal.
   c. Use of toilet or commode.

9. Prepares meals and helps patient to eat:
   a. Prepares a regular or special diet as ordered.
   b. Feeds patient or helps patient to eat.

10. Wash dishes and utensils and cleans the cooking area.

11. Plans healthy diet and buys food for patient or tells the family how to do this:
    a. Assists patient and family to follow diet prescribed by doctor.
    b. Plans well balanced diet for the patient, considering likes and dislikes.
    c. Buys economically and prepares meals.
    d. Stores food in a safe and clean manner.

12. Makes the home as comfortable as possible for the patient:
    a. Adjusts light, air and temperature.
    b. Adjusts position of bed..
    c. Arranges objects or furniture conveniently and safely.

13. Keeps bedroom and other areas in a safe, neat and clean condition:
    a. Keeps hazardous objects away from patient areas.
    b. Cleans and dusts the bedroom.

14. Cleans and makes the bed:
    a. Makes an unoccupied bed.
    b. Makes an occupied bed.
    c. Changes linens and bedding as needed.

15. Washes and irons the patient's clothing and bedding or arranges to have it done.

16. Sees that the patient takes medication prescribed by the doctor:
    a. Reminds patient to take medications.
    b. Records medications patient takes on a schedule prepared by the nurse.

17. Obtains and records information about the patient:
    a. Takes and records respirations.
    b. Takes and records pulse.
    c. Takes and records temperatures.
    d. Performs and records urine test for diabetes or helps patient to do so.

18. Recognizes and records unusual signs and symptoms of the patient and reports information to the nurse:
    a. Observes and records unusual signs and symptoms of appearance, temperament, activity and illness.
    b. Keeps daily records of HHA activities and reports to nurse.

19. Assumes usual responsibilities of the job:
    a. Makes adequate arrangements for care of children.
    b. Plans ahead for time off.
    c. Is reliable and punctual.
    d. Completes forms.
    e. Obtains adequate transportation.
    f. Is willing to work at various times when assigned, including periodic weekends and holiday duties.
    g. Is aware of personnel policies.

ACHD
1967

LESSON PLAN 11

Skin Care

OVERVIEW

Adequate care of the skin is important to prevent pressure areas and bedsores. Redness of the skin due to a part of the body bearing its weight in one position for too long a time can cause bedsores. Keeping the skin clean and dry and changing the patient's position often is very important in preventing bedsores.

OBJECTIVE

The student will be able to clean the skin and know how to keep it soft and how to prevent breaking down of the skin.

IMPORTANT WORDS TO KNOW

1. Pressure sore (bedsore) - a red area or break in the skin caused by lying in one position too long

MATERIALS NEEDED

1. Lotion
2. Oil
3. Powder
4. Basin of warm water
5. Wash cloth
6. Towel
7. Soap

METHOD AND CONTENT

1. Keeping the patient clean and dry is very important in the care of the skin. The skin should be rinsed well and dried thoroughly as soap can cause the skin to become dry and scaly.
2. Use of oil or lotion (preferably one containing lanolin) is helpful to keep dry skin soft and in good condition.
3. Each time you care for patient, inspect patient's skin. Watch for redness particularly at pressure areas or bony parts of body such as tailbone, heels, ankles, and hips.
4. Look for dryness of the skin especially of the feet, elbows, and lips.
5. Do not allow patient to remain in any one position for a long period of time as this causes pressure sores. Change patient's position at least every two hours, or more often if necessary. For proper positioning see illustrations.
6. It is important for bed patients to have a back rub at least twice a day or oftener if you see areas of redness on the patient's back.
7. See that the patient who is in a wheelchair or chair for several hours has a change of position. Periodic walks or rising to a standing position will give the necessary change.

8. Standing stimulates circulation of the legs and feet and helps prevent bedsores by relieving pressure areas. Encourage patient to stand whenever possible by holding on to the foot of the bed using his crutches or back of the chair for support.
9. Make sure patient is positioned properly in bed to prevent pressure areas and deformities.
10. Bowel and bladder control is important in preventing pressure sores.
11. Keep linen dry and free from wrinkles and crumbs that may cause skin irritation.
12. Avoid using rubber rings and doughnuts as they tend to lessen circulation and cause other pressure areas.
13. Look for early signs of bedsores before patient reports discomfort. The skin of the older person may be less sensitive to soreness or pain.
14. When you notice or when the patient complains of a sore back, heel or any areas where there is pressure, report to the nurse.
15. A diet containing the proper foods is basic to good skin condition.

IMPORTANT POINTS TO KNOW (SELF QUIZ)

1. Bedsores can be caused by two of the following:
    a. wrinkled sheet
    b. heavy blanket
    c. wet sheet
    d. obese patient

2. How often should a patient's position be changed:
    a. every hour
    b. every two hours
    c. every three hours
    d. every four hours

3. By properly positioning patients in bed you can prevent:
    a. a wrinkled bed
    b. pressure areas
    c. tiring patient

4. What can be used to keep dry skin soft? (Two answers)
    a. powder
    b. oil
    c. lotion
    d. perfume

5. Bed patients usually get pressure sores on what three areas of the body?
    a. neck
    b. tailbone
    c. abdomen
    d. hips
    e. heels

(Answers on back)

Answers to Self Quiz on other side of page

1. a. wrinkled
   c. wet sheet

2. b. every two hours

3. b. pressure areas

4. b. oil
   c. lotion

5. b. tailbone
   d. hips
   e. heels

REPORT OF FIRST GROUP COUNSELING MEETING

Gail P. Sass, M.S.W.

This was the first group meeting. It started with an introduction of leaders and an explanation that the group was a chance to discuss feelings about being a health aide and about being in the course. When the group would meet was established. It was suggested that they, themselves, might have some ideas about how the group could be used.

The group was stiff to begin with. They denied problems except for specific questions they wanted answers for. Things began to move around the idea of patients seeing the health aide as a maid. Mrs. F. seemed disturbed about this. Mrs. W. suggested just ignoring it. Mrs. S. brought up a situation about being asked to clean too much. How to explain your function, how to say "no" was discussed. The aides did not feel supported by the Public Health Nurses in the area of role definition.

Mrs. S. related another situation where she did more than was expected. She pointed out the fact that she had differentiated and she was asked on what grounds she had. Note - inconsistency in what they did could result in patients asking them to do too much. Other members of the group joined in talking about what is "too much".

The two senior health aides were called on to share with the group their observations of changes that had occurred since the aides started the course. The group denied it had felt any annoyance, worry, etc., about having to take the course. Even statements regarding the fact that they had to pass the course did not elicit any true feelings.

Mrs. C. said that she did not want patients to become dependent on her or attached to her. This was said very seriously. Mrs. W. quietly disagreed. She expressed the feeling of wanting to have people like her. Mrs. C. then talked of having called her two patients and that they wanted her to come back. She smiled and this was commented on; that she was pleased that her patients liked her and were, in fact, attached to her. She smiled broadly. The point was made that these feelings were natural, that this was where the satisfactions of being a health aide came from.

Several members mentioned, including Mrs. W., that their patients had voiced surprise that they had to take a course, that the aides would not be with them anymore. The meaning of this behavior was not commented upon. Later, however, I tried again to get back to the subject of their feelings about having to take and pass the course. Mrs. R. timidly said she had been nervous. This started others talking. The group was noticeably more comfortable in facing their feelings now. Members did admit to feeling under pressure. Mrs. P. seemed quite open in this. Mrs. L. and Mrs. W. were very worried about losing their jobs and "what would they do", if they failed. "What did they think might cause them to fail?" The first response was in regard to having to pass the test - fearful of arithmetic especially. They were asked what they thought instructors would look for in failing or passing them. Mrs. talked about "attitude". This was picked up and was tied into general comments on how the group could be used to help everyone pass and be a good health aide. Confidentiality was discussed.

The group was brought back to a consideration of "pressure" - all kinds and how it could affect a person. This was seen as an important area of further discussion. When it was indicated that the group would be ending for the day, many specific questions were asked and personal experiences were recounted. The group was reminded that because of the short duration of the group, a lot of things could not be discussed. Mrs. S. lingered after class to talk to the leaders.

REPORT OF GROUP COUNSELING MEETING ON "RECOGNIZING AND RELATING TO THE EMOTIONAL NEEDS OF PATIENTS"

Gail P. Saas, M.S.W.

Two senior aides met with the social worker to discuss the class presentation. A list of basic "Do's and Don'ts" was mimeographed for each student as well as a work list and definitions. Also there were eight questions which could be brought into the discussion at appropriate points. (Refer to Lesson Plan 54, How to Talk and Act with Elderly Patients in a Helpful Way, Home Health Aide Training Manual, HHAPTD, ACHD, 1967.

As the senior aides were detained, the social worker began the class. Going around the table, she asked each student to read a word and the definition.

The senior aides then arrived and proceeded to lead the discussion using the "Do's and Don'ts" as a guide. The senior aides proved very capable of handling the discussion, relating one point to another, relating discussion to things that this group had previously talked about. They brought the questions into the discussion in such a way as to emphasize certain points.

The students had many experiences as aides to bring up. Sometimes, they illustrated the discussion and sometimes the aide seemed to want to gain more understanding of their patient. They all showed considerable concern regarding strange behavior, things that didn't make sense, such as "crazy" people. The social worker tried to explain the continuum of normal and abnormal behavior, using common expressions and examples, i.e., "How many of us talk to ourselves once in a while?"

In general, the students seemed sensitive to the problems of the elderly. Younger patients who "should know better", posed more of a problem to them. This was very evident in their discussion of racial problems they have encountered. The prejudices of older people could be more easily dismissed than those of the younger ones. Several students reported feeling very angry. One student offered a practical way of handling this in certain instances.

She took a very direct approach in asking her patient not to say "nigger" in her presence, since he was insulting her. She learned that he really wasn't aware of insulting her. Others in the class agreed that this can happen - the patient doesn't see your "color". There were some statements expressed that Negro patients were often prejudiced about having Caucasian aides.

When the problem of becoming overly involved was discussed, one student admitted to crying about her patients when she got home. While the social worker supported her concern for her patients, the group stressed the reality that you can't carry your work home - "your own family will suffer if you get upset," etc. It was interesting to note that people without families of their own and who lived alone found it most difficult not to become personally involved. They were helped to see that they were responding to their own need.

Judging from the discussion, the group did grasp the idea of recognizing emotional needs. They started phrasing their examples differently. They started talking about patients as "lonely", "the family neglects her", "has nothing to do all day", etc. From this awareness and concern for why a patient behaves as he does, the leaders sought to move them in the direction of finding ways to help. The primary point was to consult with the nurse, identify the problem and ask for advice or see if the nurse could do something. The students wanted to know what was available for older people; could someone come and read or talk with patients who had to stay at home. They were encouraged to learn more about the resources in the community.

EXCERPTS OF REPORTS BY SENIOR HEALTH AIDE STAFF ON GROUP COUNSELING MEETINGS

"Mrs. M. stated that she had a patient for whom she did 'nothing' but clean her house and wax floors. In fact, she was doing 'nothing' until it was reported to the nurse in charge of the case. Mrs. L. had a case where she was doing a lot of extra housework until she reported it to the nurse in charge. Mrs. W. had a case where the family wanted her to do a lot of serving but Mrs. W. handled her situation differently. She related to the patient and family exactly what her duties were and that meant taking care of the patients and not serving her guests."

"Later the question was asked: How did they feel about coming back to school and what did it mean to them, returning to school and completing school. Mrs. F. said that it made her feel quite good to know that she was one of those considered to come back to class. She said she was quite nervous the first few days. She just would have to finish, she said, because it means her job if she fails. Mrs. M. said she just had to pass the course because this was the job she wanted and it was a must that she pass. That was the same view generally of the rest of the ladies. When they talked about it, you could see in their faces that they felt they had to pass."

Ramona Harvey

"The quieter students showed some difficulty expressing their thoughts while under pressure."

"Mrs. L. used an actual case experience, but because of a poor explanation, most of the group didn't understand the actual situation. Not until the actual group discussion did it become clear what the real problem with the patient was. Mrs. M. verified the situation, as she had worked with the patient also, but it didn't seem to bother her as much as it did Mrs. L."

"The second time Mrs. L. enacted her part, the group seemed to understand the problem as it existed to her. Mrs. L. does not relate well to other people and is probably creating problems for herself by not making herself understood to her associates (the PHNs). She is not trusting or outgoing in personality, but I feel she reacts well after she gets to know someone better and begins to trust them."

"As this is the last week of their schooling, all the group except Mrs. S. and Mrs. T. are expressing concern over their test and if they will pass the course."

Verna Miller

ATTACHMENT 8

____
Name

____
Date

HOME HEALTH AIDE QUIZ

Instructions

Circle the number of the best answer. More than one answer may be correct, but one answer is best.

1. If the Public Health Nurse asks the aide to do something for a patient that the aide doesn't know how to do, the aide should

   a. say so right away.
   b. say nothing, and try to figure it out alone.
   c. ask another worker.
   d. tell the Public Health Nurse you don't know how to do the procedure.

2. One day Miss Harper, an aide, gets on the bus to go home. Another aide gets on and sits beside her and says in a loud voice, "What a day! That Mrs. Carter! I spent an hour cleaning her up." Which one of these responses would it be best for Miss Harper to make?

   a. Asking with interest, "What happened to Mrs. Carter?"
   b. Saying in a matter-of-fact way, "We all have hard days occasionally as home health aides."
   c. Say kindly, "I'm sorry you had a tough day. Tell me about it."
   d. Saying in a low voice, "Let's not talk about the patients here."

3. The safety of patients will be best promoted if the actions of an aide are based on which one of these ideas?

   a. I expect to become so expert in observing patients that I will know what is important and what isn't, regardless of the situation.
   b. If a patient's appearance or behavior seems strange to me, I will report it, even if my efforts don't always seem to be appreciated.
   c. I am employed to carry out certain specific tasks as ordered, and it's not up to me to be concerned about the patients in other ways.
   d. If a patient's appearance or behavior seems peculiar, it's up to me to find out what the cause is before bothering anyone else.

4. Patients may sometimes mention religious beliefs with which the aide does not agree. Which understanding would be the best guide for the aide?

   a. It is best to pretend to have the same beliefs that the patient has.
   b. The aide has a right to explain his own beliefs in detail to the patient.
   c. When a person is sick, it is a good time to teach him true religion.
   d. Each person has a right to his own beliefs, which should be respected.

5. A certain woman patient talks constantly as long as there is anyone with her. She doesn't complain, just chatters continuously about the weather or her family or whatever comes to her mind. Which understanding should the aide have about this?

   a. The patient should be allowed to talk because it's a way she has found to make herself less anxious.
   b. It would be better for the patient if she talked about her health problems, so that everyone would know about her symptoms.
   c. The patient should be advised to conserve her energy by talking less.
   d. The aide should talk a lot too, when with the patient.

6. Miss Ellis, an aide, gets along well with almost everyone. However, one patient she is now assigned to always "rubs her the wrong way". The patient seems to get angry when Miss Ellis is around. Other team members don't seem to have this trouble. Which action by the aide would be best?

   a. Say nothing when with the patient in order to avoid trouble.
   b. Ask to have another aide carry this case.
   c. Have a "showdown" with the patient.
   d. Talk with the Public Health Nurse about the problem.

7. Which idea that an aide might have about his or her work shows the deepest understanding of human nature?

   a. "If I am nice to people, I expect them to be nice to me."
   b. "People who are sick and anxious may be cross with me because I am a safe person to be cross with. Can I bear this without getting too upset?"
   c. "If I do my job the way I should, I don't need to be concerned about what patients think of me. I'm not paid to worry about people's feelings."
   d. "If sick people get angry with me, I should ignore it."

8. In talking with sick people, among the most USELESS words we can use, in most situations, are the words

   a. "Can I help?"
   b. "I'm sorry it hurts you."
   c. "Did you sleep well?"
   d. "Don't worry."

9. It is best for the aide to AVOID getting into a conversation with patients about

   a. the value of specific drugstore remedies.
   b. styles of clothing.
   c. the growth of children.
   d. the purchase of foods and the collection of recipes.

10. The aide is cleaning the bedside tables of several patients. Which of these objects, if found in a table drawer, should certainly be reported to the Public Health Nurse?

    a. a few coins.
    b. a package of Ex-Lax (or Tums, or Peptobismol tablets, etc.)
    c. a tangle of ribbons from gift packages.
    d. a cracker left over from lunch.

11. For all nursing procedures that involve touching the patient's body, one step is

    a. drape the patient
    b. wash your hands
    c. place a protector on the bed
    d. remove at least one pillow

12. The most important hand movements in giving a backrub are

    a. long upward strokes
    b. patting movements
    c. short downward strokes
    d. circular movements

13. At the very beginning of a bed bath the clean moist washcloth is used to

    a. wash the ears thoroughly
    b. rinse off the face
    c. wipe the eyelids
    d. remove visible dirt from any part of the body

14. At the beginning of her bed bath, a patient says to the aide, "My skin seems to get drier every day". Which one of these responses would it be all right for the aide to make without asking the patient's Public Health Nurse first?

    a. "I'll rub oil all over you after your bath."
    b. "Would you like me to omit the soap in bathing you today?"
    c. "I'll sponge you off with alcohol. That should help the dryness."
    d. "Do you think a medicine may be causing the dryness? Maybe some of your medicines should be stopped."

15. It is especially important to be sure that the patient's skin is completely dry before applying

    a. lotion
    b. alcohol
    c. skin cream
    d. talcum powder

16. Which one of these articles is most essential for both tub baths and showers for feeble elderly patients?

    a. a bath thermometer
    b. a nonskid mat
    c. a long-handled brush
    d. rubbing lotion

17. If a patient asks for a razor blade to use in trimming his corns, it is best to

    a. inform the Public Health Nurse of the request
    b. find a razor blade for him
    c. give him scissors and an emery board instead
    d. tell him that medicated corn pads are safer than cutting

18. A woman patient who is recovering from a stroke has a comb with a narrow handle (rattail type). When she tries to comb her hair, she constantly drops the comb because it is hard for her to hold.

    Which of these actions by the aide would be best?

    a. comb her hair for her
    b. ask her to buy another comb
    c. tape two tongue blades securely along the handle.
    d. tell her that "practice makes perfect".

19. If a bedpan is to be put under a heavy patient whose skin tends to stick to the pan, a practical first step is to

    a. moisten the seat of the bedpan with alcohol.
    b. sprinkle talcum on the seat of the bedpan.
    c. wash and dry the buttocks.
    d. oil the buttocks.

20. When patients are incontinent (wet or soil the bed), it is sometimes possible to train them. One way the aide can help in the first stages is by

    a. trying to make the patient feel ashamed.
    b. cleaning the patient without talking to him.
    c. noticing at what time of day the patient voids or moves his bowels.
    d. telling the patient not to drink a lot of water.

21. If a member of the nursing team fails to use a deodorant, he or she will certainly be offensive to others. The last person to become aware of this offensiveness is usually

    a. a patient
    b. a co-worker
    c. the supervisor
    d. the neglectful team member

22. For which, if any, of these body areas is 99.6° F. a normal temperature?

  a. axilla
  b. mouth
  c. rectum
  d. none of the above

23. The patient's pulse has been between 90 and 110 per minute ever since the aide has been taking care of him. Now the aide finds it is 58 per minute. What next action would be best?

  a. tell the patient that he must be getting better.
  b. wait about 15 minutes and take the pulse again.
  c. call the Public Health Nurse right away.
  d. just record the pulse in the usual way.

24. When a person breathes in and then breathes out, then breathes in and out again, this is counted as

  a. one respiration
  b. two respirations
  c. three respirations
  d. four respirations

25. An adult patient lying quietly in bed has his TPR taken. The findings are: oral T., 101.8° F.; P. 116; R. 28. Which of the following judgments is correct?

  a. The temperature and the pulse and respiratory rates are all above normal.
  b. The temperature is above normal, but the pulse and respiratory rates are normal.
  c. The temperature and the pulse are above normal; the respiratory rate is below normal.
  d. The temperature and the respiratory rate are above normal; the pulse rate is normal.

26. The patient tells the aide that he has severe pain. When the aide asks where the pain is, the patient says, "It's a sharp pain in my chest. I get it every time I take a deep breath. It hurts a lot." Which of these ways of recording and reporting would be best?

  a. "Complains of pain."
  b. "Has sharp pain in chest."
  c. "Says that it hurts him to breathe."
  d. "States that severe sharp chest pain occurs with each deep breath."

27. Which of these fluid measurements is the largest?

  a. a juice glass
  b. a teacup
  c. a soup bowl
  d. a measuring cup

28. If a patient is to have a fluid intake record sheet kept at his bedside, the proper time for the aide to record the patient's fluids on that sheet is

a. when the fluids are served to him
b. when he promises to drink the fluids
c. as soon as he has drunk the fluids
d. at the end of the aide's shift (or tour of duty)

29. All of these points may be true of a well-made bed. Which one is most important?

a. The cuff made by turning the top sheet back over the spread is 8 inches wide.
b. The drawsheet is smooth and tight.
c. The heavy seam of the pillow case is toward the top of the bed.
d. The open end of the pillow case is away from the door.

30. For most patients, the part of the bedding that it is most important to have clean every day is the

a. pillow case
b. drawsheet
c. top sheet
d. spread

31. In making an occupied bed, it is desirable to leave tucks in the top covers, over the patient's feet. This is especially important if the patient

a. cannot move his legs easily
b. is restless
c. is obese
d. has small feet

32. When soiled linen has been removed from a patient's bed it should be

a. shaken
b. folded exactly, hem to hem
c. held away from one's uniform or apron
d. inspected for tears

33. Disease germs tend to scatter about and cause trouble if one dusts with

a. a damp sponge
b. an oily cloth or mop
c. a cloth or mop wet with soapy water
d. a dry cloth or mop

34. Before moving a patient up toward the head of the bed, it is generally helpful to

a. remove pillows
b. raise the headrest
c. raise the kneerest
d. remove the footboard, if present

35. A patient lying on his back has slid down in bed and needs help in moving up again. To start with, the patient should, if possible,

a. raise himself on his elbows
b. separate his legs widely
c. arch his back
d. flex (bend) his knees

36. Before helping a patient into or out of a wheelchair, which of these actions are necessary?

a. Have the brakes unlocked and the footpieces down (out).
b. Lock the brakes and have the footpieces folded (up).
c. Have the brakes unlocked and the footpieces folded (up).
d. Lock the brakes and have the footpieces down (out).

37. The aide brings a dinner tray containing a regular diet to patient. The patient's headrest is up and one of his arms is in a cast. After placing the tray conveniently for the patient, which remark or question by the aide would be best?

a. "Here is your tray. Call me if you need help."
b. "I suppose you're going to need some help. I'll be back in a little while."
c. "Can you manage by yourself?"
d. "I'll cut your meat and butter your bread. Is there anything else you'd like me to do?"

38. When feeding a patient who has a poor appetite, which of these behaviors on the aide's part is likely to encourage him to eat?

a. Telling him about the value of each kind of food.
b. Feeding him all of one kind of food before starting him on another.
c. Appearing calm and unhurried.
d. Encouraging him to talk a lot.

39. If a paralyzed patient is learning to use a spoon with his "bad" hand, which one of these foods would it be best for him to try to manage first?

a. peas
b. spaghetti
c. meatball
d. applesauce

40. If the aide feeds a patient who is blind or who has his eyes bandaged, it is important to

a. feed him all of one kind of food before starting on another
b. tell the patient what foods are on the tray
c. give him full forkfuls and spoonfuls
d. finish the meal by giving a drink of water

41. Mr. Wiley has been sick a long time. One day when the aide asks him how he feels, he answers, "This is the end. I'm not going to go on in pain and misery like this. It will be most important for the aide to

    a. suggest to him that his family would be upset to hear him talk like this
    b. tell a few jokes to try to cheer him up
    c. suggest to him that there are other people worse off than he is
    d. tell the Public Health Nurse what he said

42. If a patient is in a panic (very frightened), the aide should call the Public Health Nurse. It is also very important for the aide to

    a. keep the patient from making any noise
    b. take the patient's TPR
    c. stay with the patient until the nurse gets there
    d. try to distract the patient's attention by talking

43. If a patient on the porch said something had blown in his eye and that his eye hurt, the aide would report it right away. In addition, it would be all right to say

    a. "Don't rub your eye."
    b. "Keep your eye open."
    c. "Don't cry."
    d. "It's not serious."

44. It is nice for the aide to look cheerful and smile when entering a patient's room, but NOT if the patient is

    a. very old
    b. confused or dazed
    c. in great pain or distress
    d. shy and quiet

45. Mrs. Thompson has been in bed for several days and is now to get up. Before she gets up, she will be helped to sit on the side of the bed and "dangle" for a few minutes. The chief reason for this is to

    a. prevent dizziness or fainting
    b. make it easier to put on her robe and slippers
    c. make her feel less afraid to get up
    d. provide time to get a chair and pillows in proper position

46. If a patient has a stiff or paralyzed arm, which method of removing his soiled gown and putting on a clean one would be best?

    a. Take the sleeve of the soiled gown off the stiff or paralyzed arm first. Put the sleeve of the clean gown on the stiff or paralyzed arm first.
    b. Take the sleeve of the soiled gown off the "good" arm first. Put the sleeve of the clean gown on the stiff or paralyzed arm first.
    c. Take the sleeve of the soiled gown off the "good" arm first. Put the sleeve of the clean gown on the "good"arm first.
    d. Take the sleeve of the soiled gown off the stiff or paralyzed arm first. Put the sleeve of the clean gown on the "good" arm first.

47. A patient who is recovering from a stroke has only partial use of one side of her body. She tries to button her robe, but takes a long time. Which action by the aide would be best?

    a. Button the robe for her to save time.
    b. Tell her that one or two buttons are enough for her to do, and button the rest for her.
    c. Consider this the patient's own problem and let her handle it herself.
    d. Encourage her to button the robe, but be ready to help if she gets tired.

48. Which type of footwear would be best for a patient who is learning to walk with crutches?

    a. mules (slippers without backs)
    b. sturdy shoes
    c. slipper-socks
    d. soft bedroom slippers with a heel

49. People with poor circulation in their legs should NEVER

    a. sit with their feet up on a stool
    b. walk unnecessarily
    c. wear round garters
    d. take warm baths

50. If a patient's skin is very dry, it would be a good idea to ask the Public Health Nurse if the patient's back can be rubbed with a lotion that contains extra

    a. alcohol
    b. antiseptic
    c. oil
    d. water

51. Two middle-aged patients, Mr. Smith and Mr. Brown, seem, from the aide's point of view, to be about equally ill. The nurse who takes care of Mr. Smith says to the aide, "Don't let Mr. Smith do anything for himself, not even turn in bed or lift a glass of water." The nurse assigned to Mr. Brown says, "Encourage Mr. Brown to do things for himself. Try to get him to do a little more each day." Which understanding would it be best for the aide to have in this situation?

    a. Different nurses have different ideas about nursing care.
    b. Nurses' orders should not be questioned.
    c. Mr. Smith is getting better nursing care than Mr. Brown.
    d. Different types of illness and different stages of illness require different nursing measures.

ALAMEDA COUNTY HEALTH DEPARTMENT

HOME HEALTH AIDE TRAINING PROJECT

Food and Nutrition
Test

Multiple Choice

Instructions: Circle the letter indicating the correct answer.

1. What would be the most advisable thing to do if your patient refuses to eat meat?

   a. offer cheese or eggs
   b. give fruits, vegetables, and bread
   c. force him to eat it

2. Which groups of foods supply the most vitamin C?

   a. carrots, greens, pineapple
   b. strawberries, broccoli, cantaloupe
   c. milk, meat, eggs

3. Which is the best way to evaluate a day's menu?

   a. check to see that it includes the Four Food Groups
   b. count the calories
   c. see if it has a serving of meat

4. If a patient has poor teeth which is the most advisable thing to do about his food?

   a. grind up all his food
   b. give him only liquids
   c. serve as many naturally soft foods as possible, such as creamed dishes, puddings, etc.

5. Which is the best way to cook vegetables and prevent loss of nutrients?

   a. in a little water
   b. with soda
   c. in a lot of water

6. If round steak and pork rib chops are the same price per pound why is round steak the better buy?

   a. it has more vitamin C
   b. it will provide more servings per pound
   c. it has better protein

7. What would most accurately describe the following menu: Boiled Chicken, Mashed Potatoes, Cauliflower, and Ice Cream?

   a. it is lacking in color
   b. it has too much starch
   c. it has no protein

8. On which diabetic exchange list is bacon found?

   a. fat exchanges
   b. meat exchanges
   c. milk exchanges

9. Which of these groups of foods may a diabetic have as much as he desires?

   a. meats, cottage cheese, and liver
   b. carrots, peas, and turnips
   c. lettuce, radishes, and celery

10. If a diabetic patient receiving insulin refuses part of his meal, what should you do?

    a. don't worry about it
    b. offer other foods to replace what he did not eat
    c. give him sugar

11. Sodium is not allowed on a salt-free diet; in which of these foods is it found? (MORE THAN ONE ANSWER MAY BE CORRECT)

    a. salt
    b. baking soda
    c. "Accent"

12. A patient on a salt-free diet may not have which of the following foods? (MORE THAN ONE ANSWER MAY BE CORRECT)

    a. regular canned vegetables
    b. regular canned fruits
    c. frozen peas and lima beans

Attachment 9

ALAMEDA COUNTY HEALTH DEPARTMENT
HOME HEALTH AIDE TRAINING PROJECT

PERFORMANCE CHECK LIST

	SATISFACTORY			UNSAT.
	Classroom	Lab.	Home	Number of times
BODY MECHANICS - Did she:				
Maintain a broad base of support, one foot forward, toes pointed in direction of movement				
Stand close to the work area				
Flex hips and knees when stooping or bending				
Use longest and strongest muscles				
Carry heavy objects close to body				
Slide bed patient instead of lift				
Keep back as straight as possible				
HAND WASHING - Did she:				
Wet hands				
Work up lather				
Pay special attention to nails and between fingers				
Rinse with hands lowered				
CARE OF MOUTH AND TEETH - Did she:				
Wash her hands before starting				
Let the patient do as much as possible for self				
Brush teeth for him if unable				
Help patient rinse mouth				
BACK CARE - Did she:				
Have patient turn on side or stomach				
Protect linen				
Observe for reddened areas				
See that patient was in comfortable position				
Report reddened areas to nurse				
HANDS AND NAILS - Did she:				
Soak the hands in soapy water				
Clean area around nailbed and under nail				
File or cut nails if needed				
Have patient exercise his fingers				
Rub lotion on hands				
CARE OF FEET AND TOENAILS - Did she:				
Soak the feet				
Dry them carefully, between the toes				
Clean nails with file				
Have patient exercise feet and toes				
Report to PHN that toenails need clipping				
Tell PHN of corns, red spots, infection				
DRESSING AND UNDRESSING - Did she:				
Put paralized arm or leg in first				
Let the patient do as much for himself as possible				
Make sure patient is comfortable				
Support the joints				

Attachment 9
Page 2

	SATISFACTORY			UNSAT.
	Class-room	Lab.	Home	Number of times
CARE OF HAIR - Did she:				
Protect the patient from getting wet				
Rinse hair to remove soap				
Let patient do as much as she could to comb and set hair				
Report to nurse shampoo was given				
USE OF BEDPAN AND URINAL - Did she:				
Warm the bedpan				
Provide privacy for patient				
Use good body mechanics				
Have patient wash hands				
Look at contents before emptying				
Wash her hands				
FEEDING THE PATIENT - Did she:				
Place patient in a comfortable position				
Wash her hands and patient's hands before eating				
Let patient do as much as possible for self				
Make sure fluids not too hot				
MOVE IN BED - Did she:				
Use good body mechanics				
Tell the patient what she was going to do				
Lower back rest before starting to move patient				
Let patient help himself as much as possible				
Support the joints				
TRANSFER FROM BED TO CHAIR AND BACK - Did she:				
Tell patient what she was going to do				
Lock the brake				
Fold up foot pieces				
Stand facing the patient so patient could put hands on shoulders				
Support the patient as he stepped from footstool to floor				
See that patient moved his legs into different positions				
THERMOMETER TECHNIQUE - Did she:				
Wash hands				
Shake thermometer down to 96°				
Check to be sure she had the correct (oral or rectal) thermometer				
Read thermometer accurately				
Cleanse thermometer properly				
Record the temperature				
Report any temperature over 100° to PHN				
MAKING AN UNOCCUPIED BED - Did she:				
Make the bed in 1/2 hour				
Tuck the bottom sheet under mattress at head of bed				
Tighten the bottom cover, free from wrinkles				
Tuck the top sheet under the mattress at foot of bed				
Put top covers on bed evenly				
Support the joints				

	SATISFACTORY			UNSAT.
	Class-room	Lab.	Home	Number of times
MAKING AN OCCUPIED BED - Did she:				
Make bed in 1 hour				
Loosen the bedding all around the bed				
Turn patient to side of bed away from her				
Keep patient covered				
Turn patient toward her				
Tighten bottom sheet, free from wrinkles				
Leave the patient comfortable				
BED BATH - Did she:				
Protect patient from exposure				
Protect the linen				
See if water was correct temperature				
Let patient wash as much of self as he could				
Notice condition of patient's skin				
Report any skin problems to nurse				
Note dry skin and if so, did she use less soap				
SHOWER - Did she:				
Provide privacy for patient				
Check temperature of water before putting patient in shower				
Let patient help self as much as possible				
Notice condition of patient's skin				
Report any skin problems to nurse				
TUB BATH - Did she:				
Make sure water was correct temperature for patient before he got in				
Make sure room was warm				
Help patient in and out of tub				
Notice condition of skin				
Report any skin problems to nurse				
Let patient do as much for himself as possible				
AMBULATION - Did she:				
Tell the patient the plan of activity				
Have patient sit on edge of bed before ambulating				
Remove accident hazards from patient's pathway (i.e., clutter throw rugs)				
Stay with the patient during ambulation				
Note and report any dizziness or walking difficulty to PHN				
OVERVIEW OF THE BEDROOM - Did she:				
Put necessary items such as water, glass, comfort items within patient's reach				
Remove soiled linen				
Leave the room clean and orderly				
Put bath and eating utensils away				

ATTACHMENT 10

SELECTED COMMENTS FROM HOME HEALTH AIDE STUDENTS AT THE END OF THE FIRST SESSION WHEN ASKED TO WRITE WHAT THEY GOT OUT OF THE COURSE

"I sincerely believe that I'm ready for the nursing of H.H.A., and think that I'll improve as time goes on, because I've had quite a good deal of practice or, maybe I should say I've had a good deal of the right kind of practice, and the more of the right practice makes perfection."

"I've never yet, reached perfection but I'm putting forth every good effort and last, but not least I can truly say this, if a person doesn't learn about H.H.A. here, there is no use going no where else, because, they makes it so plain until even a little child or a stupid person could get the most of it, if not all of it, and to all of my teachers I must say, have a wonderful way of getting a job well done and that means efficiency I hope some time later on that I may be, or do as well."

"This course have ment a great deal to me, because it have provided a way and a means for me to be able to give greater aide and service to the community in which I live, and it has made it possible for me to obtain a job as long as I am and maintain a lively hood in the world that I live."

"May I quote a wonderful poet and may it be an inspiration to the class that follow, 'Heights by great men reached and kept were not attained by sudden flight but they while their companions slept kept toiling onward in the night.' So may we as home health aids try a little harder, pray a little longer and work a little harder. May we as we go out into the fields we have chosen represent this department at our highest level."

"To me it is one of the greatest thing the Government have ever did for the people, and then put the best teachers over us to teach us. I am praying and hoping this course will continue. For there is so many more like myself who want to learn nursing, as I did and not able. Oh yes, the afternoon class is great. I can read better do decimals or math write and spell and others things I were not able to do. Again I say thanks for every thing, not just for the pay, but to be able to help someone and to know how much it mean to me."

"I thought the course was wonderful. It was a good project for people 45 years and over for those that wasn't trained for a job. It is something we can do, as long as our health is good. What I got out of it - It will be impossible to put down in writing. I learned you have to think of your patient welfare before you think of yourself, also how to work with the sick until professional help get there, off course we must give credit to our wonderful instructors and teachers."

"I will say this I did learn so much about sick people some thing I wish I had know some time ago may be I could have help some one that I loved very much."

"What it ment to me - This mean that I can go on further and this is what I won't to do, I do not wont to stop here. I see ware I can get more and I am going to do this. I hope this will help me to get a better job and I think I can."

"The home Health Aide to me is very useful elightening and edicational. One thing in perticular was such subjucts you woulden think you woulden be taught to me it was amazing to know how much i didn't know about it, and how much I could learn."

"We learned a great deal about taking care of people not only physically but also psycologically which will add greatly to the comfort of people we take care of. As the program expands it will undoubtedly relieve many burdens of our society."

"Going into the Nursing home was quite a great experience for me, because I came in direct contact with a Hemophegic patient and learned more of their care. It was interesting to learn more of the care of the patient, house keeping and precautions to take in the home, to prevent falls and fires. This has been a very good experience and learning for me."

"The home health aide course was very interesting. There were many things I knew to do but was doing them wrong. Wish I had been able to have known all of this during my mother's illness."

"I think the H.H.A. program is a wonderful program especially for middle age people. In most cases it is awfully hard for people over forty-five to get certain jobs even if they are capable of doing it."

"The training program helped me in several ways. It helped me to meet the problems in my home much better. I feel that after I finish the course I will be able to go out and get a suitable job and with the help of the Health Dept. do a successful job of helping in the homes."

"I was especially favorabley impressed by the patience and understand of the instructors."

"I think this course was one of the best course that has been appropriate, first it help me to help others and it help others to help themselves. I only wish I could have known long before now, what I have learned in the past weeks. The instructors were wonderful and taken so much pain with us. I do hope the next incoming class will be as fortunate as we were."

"I greatley appreciate all the comments that has been given me while being under the direction of different teachers and supervisors, I didn't relize that I was being noticed so much, but since they have seemed to learn so much about me I appreciate the things that have been said whether they were all good or no this makes me want to work harder and do all I can to make a better home health aide or what ever may be in the future for me."

"As a student I have enjoyed every minute in class instructions have helped me to go out in the field of Health with a determination to render a service that will help our citizens to live a more healthful and wholesome life."

"This course has helped each of our communities because of the many students with varied backgrounds that inhabit these communities. Certainly each of us will start in our immediate surroundings to give aide and service whereever we are assigned, and whereever we see a need report to the proper health Dept. Authority."

"I thought the Home Health Aide Training Project was one of the most systematical record making and creating programs that I have ever heard of. I shall forever count it a blessing from God to have been chosen a student among the class of pioliting a recording creating masterplain, by such a noble staff of devinely inspired men and women of the hour."

"I have been blessed to adopt in my heart and mind a complete new approch or techque that highly motivated my thinking ability and acts of attitude and duty in caring for the ill."

"So our instructors well informed us and saw we received all the basic information of how, what and why in the care for patience. That we should always inform the patience of what you are fixing to do for him. Learn to be a good listner, always consoul but never interfear when we return home wash our hands before. Meanwhile, never carry any of your problems out of the door when you leave work for the patiences home."

ATTACHMENT 11

ALAMEDA COUNTY HEALTH DEPARTMENT

HOME HEALTH AIDE TRAINING PROJECT

Evaluation of Performance of Home Health Aide Project Student

Name of Student ________________ Name of PHN ________________
Hours employed per week ________ Date started to work ________ Date of Evaluation ________
Total hours home health aide works on cases you supervise per week ________________

	Most of the time	Some of the time	Seldom
Grooming - Clothing neat, clean and appropriate			
Team Member - Knows and assumes role of Home Health Aide			
Personal Health - Is well, no physical complaints			
Attitudes and Interpersonal Relations:			
Friendly, warm, pleasant			
Accepts annoyances and peculiarities of patient			
Listens in an understanding way			
Accepts and benefits from suggestions and criticism			
Handles Emergency Situations			
Dependable - Reports to cases on time and on days assigned			
Absences - Less than 1/2 to 1 day absent per month			
Learning Ability - Can transfer learning from one situation to another			
Confidentiality - Keeps information confidential			
Record Keeping - Keeps notes and reports problems and unusual symptoms to PHN			

TECHNICAL SKILLS: Use Performance Check List to determine important points to consider.

	Most of the time	Some of the time	Seldom
Does aide use good mechanics			
Washes hands at appropriate times			
Takes care of patient's mouth and teeth			
Gives good back care			
Cleans patient's hands and clips fingernails			
Cleans patient's feet and clips toenails			
Able to dress and undress paralized patient			
Shampoos and combs patient's hair			
Knows how to give patient bedpan or urinal			
Encourages patient to move in bed			
Uses proper transfer techniques			
Gives a good bed bath			
Makes patient's bed neatly and properly			
Gives a safe shower			
Gives a safe tub bath			
Ambulates patient properly			
Nutrition - Prepares proper diet for patient			
In your estimation is this home health aide functioning in a satisfactory manner?			

COMMENTS: (Use other side of paper if necessary)

PERFORMANCE EVALUATION ITEMS GROUPED BY FUNCTION

Professional behavior - (8 items)

Grooming - Clothing neat, clean and appropriate

Team Member - Knows and assumes role of home health aide

Personal Health - Is well, no physical complaints

Dependable - Reports to cases on time and on days assigned

Absences - Less than 1/2 to 1 day absent per month

Learning Ability - Can transfer learning from one situation to another

Confidentiality - Keeps information confidential

Record Keeping - Keeps notes and reports problems and unusual symptoms to PHN

Attitudes and Interpersonal Relations - (4 items)

Friendly, warm, pleasant

Accepts annoyances and peculiarities of patient

Listens in an understanding way

Accepts and benefits from suggestions and criticism

Technical Skills - (9 items)

Does aide use good mechanics

Uses proper transfer techniques

Washes hands at appropriate times

Gives good back care

Cleans patient's hands and feet and clips fingernails and toenails

Ambulates patient properly

Gives a good bed bath

Makes patient's bed neatly and properly

Nutrition - Prepares proper diet for patient

REPORT ON THE TRAINING OF 15 MEN IN SANITATION AND VENEREAL DISEASE CONTROL

Leroy Todd, R.S.

After the decision was made to train men as aides in venereal disease control and sanitation, 15 were recruited and selected. The men displayed a wide range in ability to both grasp and understand information as well as the ability to communicate effectively. One of the students had completed 2 years of college. Many had spent only a limited amount of time in a classroom setting. For those students who would again be placed in a classroom, the period of adjustment was somewhat difficult.

Because the majority of the students had limited reading and writing abilities, it was decided that the instructional materials should be easy to understand. Lesson plans were written in step-by-step approach; that is, each step that was required to perform a specific task was spelled out. Most of the students had no knowledge regarding sanitation or public health. In order to convey information regarding sanitation, it was necessary to develop an understanding of sanitation terminology. This vocabulary included those terms that the aide would hear most in relation to his job. Simple words were substituted for difficult ones. Unfortunately, this procedure was not adaptable for every subject which was discussed. Where word substitution was not possible, short simple definitions were used. It was apparent that some material was above the level of understanding of some students. Ability to deal in depth with technical subject matter was the actual guide for material included. With this in mind, lessons were developed around each sanitation subject. Lessons could not be developed to cover every situation the students might possibly encounter or to cover every segment of each sanitation subject. However, there was an attempt to develop lessons around those problems which were most prevalent within this area. In order to provide additional knowledge to the student regarding conditions which might constitute a health hazard, it was necessary to provide supplemental information. This was done most effectively through the use of movies, field trips, classroom demonstrations and guest lecturers. Field trips and classroom demonstrations always correlated with the subject material being covered. Field trips allowed the student to deviate from the regular classroom routine as well as aided in maintaining interest. Often a field trip or demonstration could stimulate classroom participation from those students who usually were non-vocal. Also, field trips allowed the class to break down into smaller groups and permitted more individual attention. With the development of a number of handout lessons covering various sanitation subjects, a manual was developed. Not only did each student possess material covering most of the sanitation subjects, but also he had material which would serve as a guide to most basic sanitation tasks.

Student Expectations and Problems

Some students entered the program with an indifferent and withdrawn attitude. Others entered because of curiosity, and of course the opportunity to earn decent wages. Approximately half of the students in the program were in their late forties or fifties. For the most part, these were men who had never held steady employment for any reasonable length of time. Suddenly through training, they were associating with both professionals and non-professional workers. For some this association provided the stimulus and interest to succeed in some profession or vocation. The older students tended to see the training only in terms of its financial gains, and not as a stepping stone to a better position. In such a setting, many students did not know what an agency would expect from them or what they could expect from it in terms of treatment, acceptance and assistance.

One of the major problems of the students, as a group, was that of adjustment. This was especially evident among the older students - adjusting to the realization that success depended upon one's own ability to function. Adjustment meant attending clas training, and following rules and regulations of the program. The problem of adjustment was evident in the form of chronic lateness and constant requests to be excused. A student would miss class for a number of reasons, such as to see a physician, to repair an automobile, or to handle a family affair. Frequent telephone calls during class time were a necessity for some students. These and a number of other excuses were used by the student to miss a training class.

Staff Acceptance

During the time in which the training was in process, the Health Aide Training Staff became aware about the concern among sanitarians regarding the program. Comments received ranged from "You are attempting to replace sanitarians with Aides," to "Keep them in a limited program." Such statements indicated to the staff that the program was not fully understood or accepted by all who were to be supervisors of the aides. That portion of the program which appeared most evident to the sanitarians was that there was an attempt being made not only to replace him, but also to reduce the number of sanitarians, and his importance as an integral part of the Health Department team. These opinion and attitudes were not echoed by the entire group. Nevertheless, it was evident that a number of the sanitarians showed concern regarding the objectives of the program. The question that arose was what approach would be most effective in gaining the confidence of the sanitarians and allaying any fears and anxieties among the sanitarians. It was decided to hold discussions and staff meetings between sanitarians and training staff to develop better understanding regarding the objectives of the program. It is too early to state whether the attitudes and opinions of the sanitarians have changed. At least some of the sanitarians involved in the implementation of the program have been made aware of its purpose.

ATTACHMENT 14

ALAMEDA COUNTY CIVIL SERVICE

DESCRIPTION OF HEALTH SERVICES AIDE POSITIONS

Health Services Aide Trainee

Minimum Qualifications: A person with a poverty level income.

Salary Range: 0 - $2.00/hour.

Health Services Aide I

Minimum Qualifications: Graduation from Home Health Aide Training Class of not less than 120 hours of instruction; or Home Health Aide Certificate from the State of California.

Salary Range: $395.00 - $458.00/month ($2.35/hour)

Health Services Aide II

Minimum Qualifications: Six months of experience in class of Health Services Aide I.

Salary Range: $436.00 - $505.00/month, ($2.60/hour)

Senior Health Services Aide

Minimum Qualifications:

Either I Six months experience in class of Health Services Aide II.

or II One year of experience in class of Health Services Aide I.

Salary Range: $458.00 - $556.00/month, ($2.90/hour)

Salaries correct as of July 1967.

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12/67